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ABSTRACT

The document contains the proceedings of a 1983 Tennessee conference on "Provision of Services to the Severely and Emotionally Disturbed and Austistic." Areas covered were identified as priority needs by Tennessee educators and emphasize the practical rather than the theoretical aspects of providing services. After the text of the keynote speech, papers are organized into the topics of (1) family, (2) behavioral change, (3) curriculum and assessment, and (4) program descriptions. The 24 major papers have the following titles and authors: "Meeting the Needs of Seriously Emotionally Disturbed/Behavior Disordered Students" (J. Grosenick); "Working with Parents of Adolescents Identified as Emotionally or Behaviorally Disordered" (R. McDowell); "Understanding the Diagnosis of Autism: Initial Counseling of Parents and Other Family Members" (S. Morgan); "Autism: A Family-Ecological System Perspective" (W. Haefele and S. Henggeler); "Children in Crisis--The Academic Effect" (J. Cook); "Burnout in Parents of Emotionally Disturbed Adolescents" (G. Morrison and M. Morrison); "The Role of Mental Health in the Ministry of the Church" (T. Covin); "The Use of 'Mild' Aversive Stimuli for Control of Stereotypic and Self-Injurious Behaviors" (P. Alberto); "Decreasing Aggression and Self-Harm: Prevention and Intervention Techniques Useful with the Severely Emotionally Disturbed Client" (W. Antonow and D. Orr); "Improving the Social Acceptability of Emotionally Disturbed Children" (B. Marotz); "Effects of a Self-Recording Procedure on the Attending to Task Behavior and Academic Productivity of Institutionalized Severe Behavior Disordered Adolescents" (L. Morrow et al.); "An Educational Perspective of Autism: Implications for Curriculum Development and Personnel Development" (A. Donnellan); "The Behavior Evaluation Scale" (S. McCarney); "Clinical and Educational Perspectives on Language Intervention for Children with Autism: (A. Kamhi et al.); "Visual Screening for the Severely Emotionally Disturbed Student" (A. Sizemore); "A Vocational Program and Skill Assessment for Severe/Profound Mentally Retarded and Emotionally Disturbed Retarded Adults: (S. K. Setbacken et al.); "Creative Drama for Autistic Adolescents: Expanding Leisure and Recreational Options" (C. Warger); "What We Wish They Knew" (D. Freschi); "Secondary Level Autistic Programming in a High School Setting: Debunking Myths and Suggesting Implementation Strategies" (B. Travnikar); "Putting It All Together: Programs for Autistic and Emotionally Distrubed Students in the Memphis City Schools" (E. Montague et al.); "Meeting the Needs of Autistic Individuals in a Comprehensive Community-Based Service Provider for the Developmentally Disabled" (D. Rosen et al.); "Child Mental Health Services, Inc., and the Allan Cott School" (B. Milner); "A Description of an Innovative Alternative Summer School Program for Emotionally Disturbed Adolescents in a Residential Treatment Center" (R. Devlin); and "Preparing Teachers for Children with Learning and Behavioral Disorders in a Liberal Arts College: A Criterion Performance Preparation Model" (B. Holmgren). Appended are the conference program, a list of program participants, and conference evaluation information. (DB)

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CONFERENCE PROCEEDINGS:

PROVISION OF SERVICES TO THE SEVERELY EMOTIONALLY DISTURBED AND AUTISTIC

College of Education
Department of Special Education and Rehabilitation
Memphis State University

EC 162463

MEETING THEIR NEEDS:

PROVISION OF SERVICES TO THE SEVERELY EMOTIONALLY DISTURBED AND AUTISTIC

DEPARTMENT OF SPECIAL EDUCATION & REHABILITATION
Teaching · Research · Service
THE COLLEGE OF EDUCATION
MEMPHIS STATE UNIVERSITY

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Memphis, TN 38103

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PREFACE

Meeting the needs of the severely emotionally disturbed and the autistic continues to be a primary concern of federal, state and local departments of education, and of the families, teachers, and other providers of services to this population. The broad areas addressed in the conference, "Meeting Their Needs: Provision of Services to the Severely Emotionally Disturbed and Autistic." were selected because of their immediate and recurring relevance to the needs of these groups. Identification of these needs was made through statements of priority needs by the Tennessee State Department of Education and by area school systems, from meeting with representatives of parent and professional organizations working with these target populations, through requests to our Department of Special Education and Rehabilitation for information and/or services, and from needs questionnaires filled out by participants in workshops provided as part of our grant-funded activities.

Emphasis throughout the conference was on the practical and proven possible, rather than on theoretical issues. Both oral and written reactions of conference attendees reflected appreciation of this approach. Unfortunately, not all the conference presentations are included in this Proceedings; time constraints prevented our securing copies of all papers. A brief abstract is included for each presentation for which a paper was unavailable. Requests for further information on these or other presentations will be welcomed by the presenters (addresses in Appendix).

It is hoped that publication of this Proceedings will be of help in the improvement of existing services and the planning and implementation of new programs for the severely emotionally disturbed and the autistic.

S. Odle
Project Director
May, 1983

THE KEYNOTE PRESENTATION

MEETING THE NEEDS OF SERIOUSLY EMOTIONALLY DISTURBED/BEHAVIOR DISORDERED STUDENTS

Judith K. Grosenick

MEETING THE NEEDS OF SERIOUSLY EMOTIONALLY DISTURBED/BEHAVIOR DISORDERED STUDENTS

Judith K. Grosenick
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Any discussion of the topic "meeting the needs" of any population, including seriously emotionally disturbed/behavior disordered students, assumes that these needs have been identified. I feel certain that all of us, regardless of our position, e.g., special education teacher, counselor, psychologist, administrator, parent, teacher trainer, etc., have somewhere along the way developed our own version of a "needs" list. I am no exception. In fact, it was this very concern over needs that led to the creation of the National Needs Analysis Project in Behavior Disorders, a federally funded project which I have directed since 1979.

This project has and continues to explore and publish on various need-related topics including severe behavior disorders, adolescent behavior disorders, human resource issues, psychotherapy as a related service and disciplinary exclusion of behavior disordered students to name a few. Currently, we are putting the finishing touches on documents on categorical/noncategorical programming and social/emotional/affective curriculum.

Obviously, my "needs" list as well as some of the ways to meet these needs are based upon the work of the Needs Analysis Project as well as on my own involvement in the field over the past eighteen years. One of the problems about my "needs" list, however, it that it seemingly goes on into infinity and generally creates a gloom and doom atmosphere. In fact, several years ago while the Project was in the midst of compiling the needs data, I presented the needs list and a colleague came up afterward and indicated that it was reminiscent of the bombing of Hiroshima. This reinforced several thoughts to me. First, there are a multiplicity of needs in our field. We cannot deny, overlook or soft pedal that reality. Second, it is incumbent upon us to also look carefully at how we are trying to solve these problems. There are some good practices and caring people in the field. We must learn to step back from the problem and recognize these assets, not only because they do, in fact, exist, but also for the sake of our own mental health and morale.

It is my intent, therefore, to identify six major needs from my "needs" list, briefly describe the parameters of the needs and then to point to some positive practices which may contribute to the resolution or partial resolution of the problem.

It should also be remembered that this represents my list of needs from my perspective. Yours may or may not match. Each list is somewhat idiosyncratic to one's professional position, employment setting, geographical location, etc.

Finally, nothing is implied in the sequence of the list in terms of priority or magnitude of the need. It is clear, however, that these are complex issues comprised of a multitude of sub-issues. Moreover, while the needs are presented as separate and distinct entities, reality would point to their interrelationship. This, in itself, may compound the problem even more.

Need I: Identification

The answer to the inevitable question -- where does one begin in enumerating the plethora of needs of children and youth with disordered behavior -- is, of course, the beginning. For me the beginning is identification. Within this sizable area of need I would like to focus on definition and screening and diagnosis.

Definition

Much has been written lamenting the lack of a universally accepted definition of serious emotional disturbance/behavior disorders as well as the current definition associated with Public Law 94-142. With regard to the first need, I offer no new insight. I believe Frank Wood's (1979) monograph on disturbed, disturbing or disordered behavior has provided the field with a good stimulus for discussion relative to new definitions.

With regard to discontent with the P. L. 94-142 definition, I see at least two problems. First is the issue of the label itself: serious emotional disturbance. The usage of this term because of its psychiatric connotations and its historical implications of poor parenting has raised the discomfort level of numerous professionals in the field.

A second problem relates to the use of the term serious emotional disturbance with the particular definition delineated in the regulations. Most of you are aware that the P. L. 94-142 definition is the old Bower (1960) definition which has been with us in the field for some time. To some, the label serious emotional disturbance appears to be narrow, tight, very focused; while the definition itself appears very broad. This creates a certain amount of dissonance. Moreover, the Bower definition has historically been associated with the general term emotional disturbance/emotional handicapped, in a sense representing all levels of disturbance, mild, moderate and severe. To find it suddenly attached to the label serious emotional disturbance is disconcerting.

The confusion is best evidenced in schools that we visit which had established self-contained classes for the severely emotionally disturbed. One must assume that under such a conceptualization classes for mild and moderate seriously emotionally disturbed could also be established.

There are other problems related to the label and definition including the relationship between serious emotional disturbance and social maladjustment, serious emotional disturbance and juvenile delinquency and serious emotional disturbance and autism. This latter relationship seemingly has been resolved with the transfer of autism to a different category.

Screening and Diagnosis

There is a multiplicity of needs related to screening and diagnosis that is creating problems in the field. I will enumerate only a few.

1. Lack of Conceptualization: This criticism has been leveled particularly at the screening end of the process. Understanding what screening is, its purpose, who conducts it and how it is differentiated from assessment/diagnosis is sorely lacking in many school districts.

2. Quality of Instrumentation: We are all too painfully aware of the inadequacy of the instrumentation we have available to us, particularly in the social/emotional/behavioral areas. This lack has to impinge on the identification process and we must be prepared to deal with the implication.

3. Growing Waiting Lists: The 1982 report to Congress on the implementation of P.L. 94-142 draws attention to the problem of the growing number of children who are being placed on waiting lists to be evaluated. Because of factors such as: (a) re-evaluations, (b) personnel shortages, (c) uneven demands for evaluation, (d) difficulties in coordinating resources, (e) reliance on outside agencies for evaluations and (f) delays in sharing evaluation information among agencies, the timelines between referrals and actual evaluation have increased considerably. While the phenomenon is not just confined to seriously emotionally disturbed students, one can well imagine the tension that the system experiences when delays are encountered in moving this type of student through the identification process in a timely fashion.

4. Under-referrals: The problem of the number of unserved seriously emotionally disturbed children will be addressed in a later section. However, there are other practices which have been noted that speak specifically to the actual nonidentification of students as seriously emotionally disturbed. For example, fear of parental reaction has been a deterrent to referrals in some school districts. Also encountered have been administrators who bluntly inform teachers that no referrals for consideration as seriously emotionally disturbed will be taken because no services exist. Finally, an

interesting phenomenon of "delayed identification" has been documented. In this case, students are not openly evaluated as seriously emotionally disturbed. However, once the school district has located a teacher to staff a class of seriously emotionally disturbed students the class is automatically full.

5. Over-referrals: It seems safe to assume that if one end of the problem, that is, under-referrals, exists in some schools, so does the opposite end, i.e., over-referral. Concerns related to over-referral usually focus on (a) the large number of minority children and youth referred for evaluation as seriously emotionally disturbed, especially in metropolitan areas; and (b) the large number of children referred without an adequate attempt to intervene and problem solve at a building level prior to that referral. In a sense, this is analogous to exhausting one's administrative remedies. In some school districts, it is readily apparent that students are being referred for evaluation as seriously emotionally disturbed with minimal documentation of attempts to solve the problem at the local building level.

Finally, while not constituting over-referral, we must be alert to the sizeable increase in the number of secondary school students who are being referred for evaluation as seriously emotionally disturbed. Along with learning disabilities this constitutes the overwhelming majority of students being referred at the secondary school level. This must be put in the context that screening and diagnosis is less well-defined and implemented at the secondary level and the majority of secondary level regular education teachers have not been well trained relative to identifying and programming for handicapped students.

Directions for Resolution

Time does not permit discussing the possible resolution of identification needs in a thorough, studied fashion. At best, I can toss out a few teasers to serve as a stimulus for more debate and discussion. I would not even label this food for thought. It more closely resembles snacks or munchies.

With regard to definition, I would recall your attention to Frank Wood's monograph. By examining the current state-of-the-art of definitions, the components of a good definition and the various purposes and usages of definitions, I believe this document has provided a good foundation for the next step of postulating a definition of emotional disturbance/behavior disorders.

Our project has already taken a stand on terminology. We prefer behavior disorders to serious emotional disturbance. This is discussed at length in several of our documents so I will not reiterate our reasons here. It should be noted to allay the fears of those who would predict a rash of over-referrals accompanying the use of the broader term of behavior disorders that such a phenomenon is not substantiated. Analysis and comparison of the number of children served in states using broad labels such as behavior disorders, behaviorally impaired, etc. and those using the more focused label of serious emotionally disturbed, emotionally maladjusted, etc. reveal no significant differences.

It is my understanding that the Executive Committee of the Council for Children with Behavior Disorders as well as Council for Exceptional Children are supportive of this change of label. Work is underway to seek this label change within the 94-142 statutes.

With regard to screening and diagnosis a few positive directions also merit highlighting. While we decry our current lack of adequate instrumentation, it is apparent that many school districts have met this void through the establishment of a sound evaluative process which includes all the legal safeguards such as multifaceted evaluation, direct observation, parent involvement, etc. This seems to be the most productive route to follow. Thus, rather than relying on one instrument/person to establish the existence of a handicapping condition, a process which is multi-stepped, multi-sourced, multi-disciplinary, etc. will provide a firmer foundation for the diagnosis of serious emotional disturbance.

On the other hand, I am aware that the testing market is seeing an increase in the number of instruments being generated in the area of behavior disorders. Peer, self, parent and teacher behavior rating scales are emerging on the market. Some of these, hopefully, will prove to be useful as part of an evaluation process.

Finally, identification of behavior disordered/seriously emotionally disturbed children and youth is receiving much attention via inservice. Many states have made the entire area of serious emotional disturbance a training priority as reflected within their comprehensive systems of personnel development plans (CSPD). Naturally, within that broad area, a logical beginning point for inservice is identification.

Need II: Human Resources

The area of human resources is broad indeed. It includes not only the target population of children and youth with whom we are concerned but also regular and special education teachers; local program supervisors and administrators; support personnel such as counselors, psychologists, therapists; and even state-level supervisors and administrators. For our purposes, however, the focus will be confined to the target population of children and youth and special education teachers.

Students Served/Unserved

It comes as no surprise to most professionals in the field that the area of serious emotional disturbance represents one of the most significantly unserved populations. The advent of Public Law 94-142 and its required documentation turned what has heretofore been a suspicion into a reality.

The 1982 report of Congress indicates that serious emotional disturbance is one of three categorical areas which has experienced significant increases in children identified and served. As of 1980-81 approximately 349,000 seriously emotionally disturbed students were served as compared to 283,000 in 1976-77. This constitutes approximately 8 percent of all the handicapped children served.

How many should we be serving? The question continues to be a topic of controversy. Literature and research findings quote estimates from one percent through 35 percent. In the initial stages of P.L. 94-142, Special Education Programs (the Office of Special Education) used a two percent figure as the expected prevalence of serious emotional disturbance. Early data from the states indicated that just over 50 percent of the school age population was being counted. Interestingly, in subsequent Congressional reports, Special Education Programs altered the expected prevalence to 1.2 to 2 percent. Even then states were still only serving on the average of 80 percent. What may be even more interesting is that the latest report to Congress omits such data altogether. Despite this absence, there seems to be a pervasive belief that there are still significant numbers of school age students who are disordered by virtue of their behavior and are unidentified and/or unserved.

Special Education Teachers

In addition to teachers, seriously emotionally disturbed children and youth are served by a wide range of administrative and ancillary personnel. However, the bulk of educational contact with and service delivery to these students is provided by teachers certified in serious emotional disturbance.

The needs relating to the area of teaching personnel focus on both quantity and quality. The need in terms of sheer numbers is clearly documented. Serious emotional disturbance is one of four areas in special education that is in greatest need of teachers. In fact, according to a study (1980) by the National Association of State Directors of Special Education (NASDSE) the need for teachers with serious emotional disturbance was rated as critical. This state of affairs has been confirmed by other researchers (Schofer & Duncan, 1980) who report that over 90 percent of the states indicate that demand for teachers exceeds supply in behavior disorders. Moreover, half the states rate these shortages as most severe.

The concern over quality in personnel revolves around the widespread practice of employing less than fully certified teachers. Obviously, with a dire lack of fully trained teachers to staff classes for seriously emotionally disturbed children and youth, service delivery providers have been forced to draw upon less than fully certified personnel. In general, our study found that temporary certification ranged between 20 to 50 percent statewide, with tremendous variance between school districts and service delivery facilities. For example, public school programs **usually** have the least temporary certification, yet in some rural areas, it may run as high as 75 percent. Mental health and correctional facilities also rely more heavily on temporary certification. Sometimes as much as 80 percent of their teaching staff hold temporary certification.

Finally, one cannot discuss teacher supply and demand, at least in this day and age, without mentioning attrition and burnout. When discussing the topic it really is critical that we do not equate attrition and burnout. Burnout seems more appropriately classified as one of many reasons why people leave the profession each year. While burnout may be a significant contributor to attrition, particularly in the area of serious emotional disturbance, recent studies are pointing to economics and family reasons -- accommodating a spouse -- as leading factors behind attrition.

Ironically, economics is also hypothesized as having the reverse effect on attrition, that is, given high unemployment in other fields, teachers are less inclined to leave their positions as readily as before. This was one explanation proffered for the decrease in attrition rates in a recent replication of an earlier study which had found attrition rates as high as 21 percent for teachers in the area of serious emotional disturbance.

Even with lowering attrition rates, at least in some states, there is a differential within the pattern of attrition. Rural areas, for example, suffer more attrition than urban areas. Adolescent programs in the area of serious emotional disturbance experience more attrition than elementary programs. Programs for the most severely disturbed students lose teachers faster than programs for mild/moderately impaired.

One less well-known fact that concerns me particularly as a teacher educator is that approximately 20 percent of graduates from training programs in behavior disorders never make it to the marketplace. That represents another drain on the potential workforce which our field cannot clearly stand.

Directions for Resolution

The needs in the area of human resources truly reflect a complex set of problems. For that reason, it is more difficult to identify isolated practices which are addressing these needs.

Certainly the numbers of children served and programs created have grown and we must take heart in that. However, we have a long way to go to approximate most commonly accepted prevalence estimates. For that reason, it is encouraging to see that at the national level and in many states the press for programming in the area of serious emotional disturbance is still a priority. That kind of emphasis will be necessary if we are ever going to be able to reach a point where professionals feel we are serving a more realistic proportion of those in need.

The need for additional teachers in the field presents an equally perplexing problem. It is hard for us to propose solutions when a significant portion of the problem relates to economic issues, e.g., teacher salaries, successful bond issues and tax levy campaigns, etc. In the National Needs Analysis Project's document on human resource issues (1980), several suggestions were made which still warrant serious exploration. They include:

1. Active Recruitment: Training programs must develop and plan active recruitment campaigns in the area of serious emotional disturbance. For most programs, this will be a real shift in position since we have historically been waiting for students to come to us. However, with enrollments in higher education declining to some degree in the next few years, active recruitment may be a realistic activity for a host of reasons. In general, recruitment efforts should be focused on the areas of greatest need. For example, there appears to be proportionately greater shortages of qualified persons to teach the adolescent, the severely behavior disordered and for positions in non-public school settings. In order to attack the problem of teacher shortage in rural areas, intensive recruitment of persons from geographical areas experiencing such shortages must be considered.

2. Field-Based Off-Campus Training: Some training institutions have already explored and/or implemented training programs that are delivered predominantly off-campus. While numerous problems may be encountered in the effort, the concept merits serious consideration for several reasons. For purposes of this discussion, however, we should not overlook the positive impact this potentially could have on reducing teacher shortages in the specific geographical area in which the training program is being offered.

3. Staff Respite: Local school districts are beginning to consider this possibility. The usual method is that a teacher is entitled to a year's sabbatical at full or partial pay after completion of a certain number of years in the district (often 3-5). Additionally, the teacher agrees to return to the district for one or two years following the sabbatical. This process allows for a teacher to regenerate rather than "burnout".

4. Accumulation of Seniority: Another positive consideration in some school districts is the tabulation of seniority across all years of teaching experience, not just for years in a given specialization. Thus, a teacher who teaches **five** years in behavior disorders and then chooses to teach two years in learning disabilities accumulates seven years of seniority rather than just two. By not limiting seniority to status in one specialization, teachers can more readily consider taking positions with more difficult students since they will not lose seniority if they should ever wish to change roles again in the future.

5. Attention to Environmental Factors: One of the positive benefits of all the research into the topic of burnout and attrition is the information and direction it points toward for solving the problem. Our initial response to the issue of burnout was to increase the number of inservice sessions on stress management, time management, relaxation strategies, etc. These certainly fill a needed void. However, the attrition research is also showing us that there are other factors such as the school climate, the administrator's attitude, etc. which also contribute significantly to feeling burned out. We must not overlook those aspects of the school environment when we want to launch a successful campaign to reduce burnout.

6. Teacher Support Systems: Interestingly, we are seeing a resurgence of informal and formal networking among teachers of the seriously emotionally disturbed. While such support groups had been prevalent in the late 1960's they decreased in their visibility, if not number, during the 1970's. Now we hear teachers clamoring more for opportunities to talk to one another, share ideas, etc. Even in large districts where a teacher of a class for behavior disordered children may not be the only one such animal in a building, such support is being sought. Some of this may be related to the fact that program supervisors and administrators who once had time to stop by classrooms, observe, offer suggestions, etc. are now inundated with paperwork and due process and are not available to provide the support they previously had.

7. Employee Assistance Groups: Finally, reflecting perhaps a combination of #5 and #6, there is a movement underway to establish employee assistance groups within schools. This is a model adopted from industry. It basically is designed on the premise that certain employees may be encountering problems, e.g., stress, drugs, alcohol, financial difficulty, which interfere with their productivity. If the problem could be remediated, however, the employee would be a valuable contributing member of the team. Thus, a variety of services, including counseling, financial advisement, etc., is available to help the employee get back on the track. Such programs have potential for teachers we suspect of drifting into the later stages of psychological and/or physical burnout.

Need III: Service Delivery

It comes as no surprise that the public schools are the major provider of educational services to seriously emotionally disturbed children and youth. Anywhere from 75 to 95 percent of the population are served within the public schools.

As might also be expected, if one surveys an entire state, a range of program options are available for this population. Included among the types of programs available are itinerant services, resource rooms, self-contained classes, special schools, out-of-district day placement, out-of-district residential placement, consultant teachers and homebound instruction. According to the 1982 report to Congress approximately 40 percent of the behavior disordered population are served in the regular classroom with aid and support for less than 50 percent of the day. Almost an equal number is served in separate classes, while the remaining percentage is predominantly served in separate, special schools.

As indicated within states, a continuum of services is usually observable. However, the probability is much smaller that a full continuum of services exists within individual districts within a state. Hence, it is not uncommon to find gaps in the range of services. The most frequently encountered holes in the system are:

Lack of Regular Education Alternatives

Many students in public school settings exhibit a variety of behavioral difficulties for which classroom teachers would like assistance. Lack of in-building alternatives other than special education to assist classroom teachers in dealing with student's behavioral problems has contributed to over-referral, inappropriate verification for eligibility and total reliance on special education services for handicapped student programming.

Inadequate Options at the Secondary Level

Services for seriously emotionally disturbed adolescents on any widespread basis is a relatively new addition of the continuum of services. Even so, there is general consensus that seriously emotionally disturbed adolescents are among the least appropriately served students with special needs. This may be the result of a variety of reasons including difficulty of providing services, inadequately trained teachers or uncertainty for eligibility. Certainly, one most commonly encountered reason is the lack of options at the secondary level. This lack has translated into usage of a variety of exclusionary provisions as a major intervention for behavior disordered youth. Such techniques as continuous suspension, in-school suspension, shortened school day, administrative transfer, ignored truancy and homebound are frequently encountered as means for dealing with adolescent age behavior disordered students. While some of these may have an appropriate place in the disciplinary life of a school, their heavy usage with specific populations leads to questions regarding the provision of an appropriate education.

Lack of Career/Vocational Programming

Closely correlated is the lack of programming in career and vocational areas. Currently the number of seriously emotionally disturbed students participating in such options is minuscule. Whether because these options have not been developed as of yet or because behavior disordered students are being denied access to such programs, the end result is the same.

Lack of Services Across Community Agencies

The previous factors listed represent voids in an inadequate continuum of services within an educational context. There are communities and states, however, that have severe gaps in a broader sense that limit services to seriously emotionally disturbed children and their families outside of school. It is apparent that the family and out-of-school environment have a major impact on a seriously emotionally disturbed student, his/her progress and the school program. Inadequate support services for this family and out-of-school environment adversely affect student progress and lower efficiency and effectiveness of the school program. Usually the problem of insufficient support systems for families of seriously emotionally disturbed children is twofold in nature. First, some needed support services are not available and second, services that are available are not provided on a coordinated basis. This latter problem really jumps ahead to our fourth area of need on interagency collaboration. Let us simply note here that among the support services most frequently lacking are (a) assistance in dealing with personal and interpersonal issues within and among family members, (b) the development of skills necessary to assist a family to remain intact, and (c) need for expanded continuum of care options such as respite care, crisis intervention, foster care, group home and even in some states, residential facilities.

Directions for Resolution

There is virtually no way within the parameters of my task that I can list and describe the numerous good or promising practices that school districts and other service providers are doing for seriously emotionally disturbed children and youth across the nation. Conferences such as this one, however, usually facilitate that flow of information through minisessions, cracker-barrel sessions and small group sharing. I have chosen to highlight only a couple of areas that warrant our attention.

1. School districts are exploring a wide array of alternative interventions or support services for implementation at the building level. Options such as (a) rearranging class schedules, (b) changing a student's teacher, (c) counseling, (d) crisis intervention teacher, (e) alternative learning centers, and (f) behavioral consultants are a sample of some less intensive options. In addition, some buildings have adopted the concept of a "teacher assistance team". This mechanism is designed to assist classroom teachers in handling mild to moderate behavioral problems in the classroom as well as those identified behavior disordered students who are mainstreamed. The teacher assistance team concept involves a pre-referral team meeting process which is aimed at generating alternative intervention strategies for dealing with behavioral problems. It is anticipated that generation of alternatives by building level personnel will foster a consistent and improved data base for the diagnosis of behavioral disorders. By utilizing in-building alternatives, classroom teachers receive assistance with students with behavioral difficulties and at the same time collect behavioral data relative to the effect of the building interventions for decision-making. Use of in-building generated alternatives by the building "team" places emphasis on expertise at the school level to solve behavior problems and assists teachers so that only the most severe, and, hence, those most likely to be verified, are ultimately referred. The process involved with the use of a building level team may provide a way for teachers to receive assistance in intervening with students with mild to moderate behavioral difficulties without going through a time consuming and costly diagnostic process.

2. In light of the shortage of teachers in the area of serious emotional disturbance, noncategorical and/or cross-categorical programs are being advocated as one of the solutions to the problem, particularly in rural areas. There are strongly dichotomized opinions

regarding the desirability of this move. Proponents of the movement support its shift away from the stigma of labeling while asserting that the pool of potential teachers for seriously emotionally disturbed children would increase. Those opposed to the move maintain that such programs may hypothetically increase the teacher pool but, in reality, drastically reduce the number of persons committed to the unique problems of seriously emotionally disturbed children and youth, especially the more severe problems. In practice, the critics maintain that non-categorically certified teachers seek less stressful, less frustrating job positions. These positions seldom include behavior disordered children and youth. I do not intend to try to resolve that issue today. However, we are witnessing a growth of non-categorical programs and thus they represent an attempt to resolve the service delivery problems, particularly for rural areas.

3. Slowly the area of vocational/career education is opening up for the adolescent behavior disordered population. Some options other than college-bound curriculum are beginning to open access to our youth. Work study programs, pre-vocational study programs, simulated work experiences, off-campus work stations and cooperative programming with area vocational-technical schools are possibilities that exist in some places in small numbers.

4. Since I listed voids in the community care continuum under service delivery, I will call your attention to the increasing number of collaborative programs that are being started to address these voids. Through cooperative efforts between agencies such as school districts and mental health, school districts and corrections, school districts and private providers, extended day programs, after-care programs, transition (reintegration) programs, and parent training programs are being gradually developed to provide support to the behavior disordered student and/or his/her parents.

Need IV: Interagency Collaboration

The area of interagency collaboration has grown and flourished in the last 5-7 years for numerous reasons not least of which were the Federal mandates, economic constraints and pressures from the consumer/client. Trying to promote two or more agencies to work together to openly and honestly discuss, plan, implement and evaluate ideas and programs is an awesome task. It is also frustrating and tiring. It can be challenging and rewarding if and when the mutual goals are finally reached.

There are a multitude of ways in which agencies can collaborate anywhere along the continuum of programming for behavior disordered students from planning, identification, service delivery and program evaluation. It is important, however, that we keep uppermost in our minds that collaboration is a process. It is not just a paper product called an interagency agreement. In the press for implementation of the Federal mandate we witnessed a flourish of interagency agreements, joint memorandums, executive orders, etc. all designed to attest to the existence of a process. Unfortunately, we found out that many of these paper agreements reflected no collaboration at all. When one looks at the obstacles in the way of collaboration, it is no surprise that such efforts are few and far between. Competition for declining resources, conflicts in statutory mandates, duplication of services, lack of communication, problems of confidentiality and transfer of records, lack of information sharing, inadequately trained staff for collaboration, philosophical differences, and resistance to change are only a few (and I emphasize a few) of the many barriers facing the people who attempt to address the need for collaborative efforts.

Directions for Resolution

Given the dearth of what is being done in the general area of interagency collaboration, we find ourselves at a fairly primitive level relative to a base of information. However, there are an increasing number of efforts underway. Let me mention a few.

Several states have established, on a pilot basis, a case management team for the state or a specific geographic region therein to discuss and resolve the treatment of particularly troublesome children and youth. This population, predominately behavior disordered, has usually been through a multiplicity of services within a city, county or state, exhausting all these services and still yet remaining a problem. By bringing together agency decision makers with the focus on delivery of service to untreatable students, not only do the barriers become quickly identified, but perhaps more quickly resolved. It simply represents one approach to mutual problem solving.

My own project, an offshoot of the National Needs Analysis Project, has been working with interagency leadership cadres from two to three states to identify and implement activities which are interagency in nature and which have as a goal the improvement of services to seriously emotionally disturbed children and youth.

I just recently returned from a visit to Dallas where I interacted with an interagency task force of local directors of special education, educational directors in state mental health facilities, correctional facilities and private residential treatment centers. This group is working to establish better transition programs for severely disturbed adolescents who get shunted (and usually lost) between and among those various systems. I mention this project in particular because of its inclusion of the private providers as partners in collaboration.

John McLaughlin and his colleagues are working from a different perspective. They have developed training materials including simulation games to help persons involved in the collaborative process. As I indicated earlier, one of the obstacles to collaboration is that personnel from decision makers to grass roots deliverers of service have had little experience in working together collaboratively. Thus, there is a real need in the area for training materials. As you might expect, much of the focus of such training is on communication since this seems to be the single most critical component to successful collaboration.

Need V: Advocacy/Parents/Community

While a few factors regarding parents and community have been mentioned, there are several others that alsc merit attention.

Advocacy

Advocates on behalf of children and youth with disordered behavior take many forms: individuals, agencies, and organizations. Usually if one digs deep and long enough, one finds such a group within a state. This may include parents, mental health personnel, teachers of behavior disordered children and youth and trainers of teachers of behavior disordered children and youth. While finding such a group is not impossible, the evaluation of the effectiveness of most of these groups is moderate at best. This is particularly true when viewed in light of the strong advocacy movements in other areas of special education.

Parent Skill/Attitude

The needs that relate to parents of seriously emotionally disturbed children and youth are multifold. For example, some parents lack basic parenting skills or skills to control their children. Some parents with marginal parenting skills find themselves pushed to their limits especially in the press of today's economic pressures. It becomes easier to give up. One simply has no other energy to give to controlling the family. Of course, we have, and continue to face, parents whose views on the value of education differ from ours.

Community Support

When we talk about community support in many respects we are talking about community attitudes. While not all the negative feelings communities have about supporting education is directed toward children with disordered behavior, it most certainly affects them. Moreover, we are well aware in many small communities that the child or youth with serious emotional problems is highly visible, well-known to the community and usually not well liked. It is interesting to see in those "infamous family" cases in small towns how the community has no sense of ownership of that child or his/her problems.

Another problem that is straining community attitudes is that of violence in the schools. Junior and senior high schools are plagued with a variety of forms of violence, e.g., verbal abuse, vandalism, personal violence, theft, disruption, etc. Certainly we are aware that a large percentage of these offenses are not committed by students labeled behavior disordered. On the other hand, some are. My concern rests not so much with numbers or percentages of behavior disordered students involved in crimes of violence but rather with the potential effect of **interventions that schools** are using to combat this violence. The successful strategies to decrease high rates of violence focus on increased disciplinary intervention (as opposed to security). For a population, such as seriously emotionally disturbed youth who have difficulty with rule-following behavior, heightened emphasis on discipline could prove to be problematic.

Directions for Resolution

Whenever we talk about attitudes it seems that we find ourselves on softer ground relative to directions for resolution. Certainly, I feel that way when we discuss community attitudes, perhaps less so when we discuss parental attitudes and skills.

Parent involvement, of course, has increased with the advent of P.L. 94-142. Numbers document the quantitative nature of that involvement. There still remain some questions about the quality of that involvement. However, work by professionals such as Roger Kroth, Richard McDowell and their colleagues have done much to help teachers, both regular and special, to interact with parents in more positive ways. The work of these gentlemen is among the notables on the growing list of programs in the area of parent education, parent awareness, communication with parents, parenting skills, etc.

The advent of mainstreaming also was accompanied by an increased attention to the attitudes of others -- other teachers, other students, other parents, other professionals -- toward the handicapped, including the seriously emotionally disturbed. Training materials usually with heavy emphasis on simulation have been marketed to heighten other's sensitivity to the handicapped. I really have not seen much evidence of impact of these materials, however, on our area.

That does not lessen the need to address the attitudinal issue. It is critical that persons, both internal and external to the school, have a better understanding of programs for seriously disturbed students. As simplistic as it sounds, it is essential that before programs for behavior disordered students are initiated in any school district/building all necessary and appropriate groundwork be laid. All too often students are identified as seriously emotionally disturbed and when sufficient numbers of such accumulate, a class is started. Such an approach is definitely not built upon mutual understanding. Instead, a first step in matching the expectations of educators having responsibility for BD programs is to discuss their particular expectations of such programs. All levels of personnel within the districts (from the school board, to district administrators/supervisors, to building administrators, to regular educators, and BD teachers) should explore what their expectations are as part of the process involved in defining district policy on programs for behaviorally disordered children and youth. This has particular relevance in relation to discipline policies and practices.

The initial leadership role should be carried by central administrative/supervisory staff. They should assist a building in preparing to implement a program for behavior disordered students. The building administrator(s), guidance counselors, special teachers, and appropriate central administrator should reach some level of agreement on what that program is to accomplish. Once consensus on this has been reached, it becomes possible to discuss how to utilize the special teacher as well as the other resources in the building. Such preparation should help narrow the differences in expectation and consequently enhance the services to behavior disordered students.

Finally, professional organizations in the area of behavior disorders should also consider mechanisms which they might sponsor which would enhance community understanding of seriously emotionally disturbed children and youth and programs for this population. As indicated earlier, the attitudinal problem is not confined to the educational profession, but pervades communities at large. Given that few formal advocacy groups exist in the area of behavior disorders, the task of educating communities must fall to other parts of the system. It may well be that professional organizations in the area of behavior disorders are logical and appropriate vehicles for organizing and implementing community awareness campaigns.

Need VI: Training

As a teacher trainer in the area of behavior disorders, it would be impossible for me to discuss needs and need resolution without some mention of training, both preservice and inservice. By preservice, I mean that college or university training leading to a degree and/or certification which precedes employment with the population under consideration. Inservice, on the other hand, is training delivered to personnel currently employed in serving behavior disordered children and youth.

Preservice

The problems of preservice training are multifold and include concerns with program content, numbers of students and number and quality of the teacher trainers. Only a few brief observations on lack of these do I have time to share.

First, although services to behavior disordered children and youth occur in different environments, i.e., public school, facilities for neglected or delinquent, mental health facilities, and private schools, there appear few systematic efforts to train teachers differentially at the preservice level. Almost without exception, colleges and universities report that the only distinction in training programs relative to eventual service delivery environment is the type of placement a student receives for his/her practicum (student teaching) experience. I am not certain how much or what form such training would take in order to insure that our graduates can function adequately across differential service delivery systems. I simply am aware that state and local education agency persons continue to express concern that our program graduates are not prepared for the jobs ahead of them, particularly in youth corrections, mental health facilities and adolescent age behavior disordered programs in the public schools. We need also to remember that training for this range of environments is usually being conducted in programs staffed by one, two, or three persons.

While on the topic of numbers, the University is making it increasingly more difficult to ignore number of students. If you remember that in most states, training institutions, in combination, are producing less than 1/5 of all teachers of serious emotionally disturbed children and youth, you can see how small most training programs are. Given declining enrollments in higher education accompanied by decreasing fiscal resources, such small programs will come under greater scrutiny in the next decade. Fortunately, the case for need is usually so dramatic that we have enjoyed less threat than some of the other training programs in education.

Inservice

The area of inservice training has expanded greatly since the passage of P.L. 94-142. By far, the largest amount of inservice conducted, is done so by the public schools. Most of the training, however, has been oriented to regular education faculty and emphasizes behavior management, behavior modification, mainstreaming behavior disordered students and identification of emotional problems. In fact, many states have designated behavior disorders as one of the highest training priorities on the comprehensive systems of personnel development plans (CSPD). While such effort and emphasis is laudable, we must not overlook providing inservices to the teachers of behavior disordered children and youth. I am aware of several states that have become increasingly sensitive to this work and are designing workshops, conferences and other varied educational experiences that focus on specific needs of behavior disordered children and youth.

Finally, there has been universal disenchantment with the historically used "Dog and Pony Show." This is a one person, two hour spiel on a currently popular "topic". This is not to imply that such forms of inservice have no role within the overall conceptualization of inservice. Quite the opposite is true. It is valuable basically as an awareness, consciousness-raising technique. As such, it is an initial step in most learning processes. The problem lies in the fact that most schools and institutions seek inservice as a way to upgrade the skills of their staff; that is, they are looking for behavior change in their personnel. They perceive, often quite accurately, that this sort of "inservice" does not effect that change. Unfortunately when such inservice does not provide behavior change, they then feel that they have wasted time and money on "inservice." Persons who provided this type of inservice are equally upset since the implication is that they weren't "good enough" or "didn't do their job well." In fact, many inservice providers now refuse to be involved in such sessions due to the growing, and somewhat unfair, criticism of that work. It is imperative, therefore, that inservice providers and recipients are clearly aware of the goals of any specific inservice and that such programs are consonant with the expectation of both parties.

More serious is the need on the part of providers and recipients of inservice to rethink the entire process. If the goal of behavior change is a valid one, and most would agree that it is, then it is necessary to incorporate what we know about learning processes into the delivery of inservice. Recipients of inservice cannot expect to get large scale behavior change from one, two or three two-hour sessions per year. Providers cannot expect to accomplish that goal within that format. Therefore, inservice designed to provide behavior change must be reconceptualized as an integrated, ongoing process which requires a time and money commitment on the part of recipients.

Directions for Resolution

Several of the positive steps underway in the area of training have already been mentioned. State CSPD plans reflect serious emotional disturbance as a priority. In fact, several years ago, the Division of Personnel Preparation, Special Education Programs, activated a training initiative in the area of serious emotional disturbance. Certainly such efforts emphasize the relative import of behavior disorders among the numberous and varied training needs in special education.

The last few years have also witnessed an increasing number of conferences, such as this one with a focused concern on seriously emotionally disturbed children and youth. CEC, for example, held a topical conference on behavior disorders only a couple of years ago, followed by a second one which Sheldon Braaten hosted in Minneapolis last September. The states of Missouri, Nebraska, Iowa, and Kansas formed a consortium and sponsored a Midwest symposium for leadership persons in behavior disorders this past February. I am certain there are numerous others across the nation. These provide excellent, smaller, more intimate opportunities to learn and share than can sometimes be achieved at large organizational conventions.

New approaches to training including competency-based, noncategorical, field-based models are being explored as possible means to enhance both quality and quantity in training. These have been mentioned previously as well as the need for more active student recruitment.

Recently, too, we have seen more local and state inservice which brings together service delivery personnel from a variety of facilities, i.e., public schools, mental health facilities, private treatment facilities and correctional facilities. This trend has several benefits attached to it including enhancing interagency awareness, communication and collaboration.

Conclusion

It is apparent as one examines the major needs associated with educating seriously emotionally disturbed children and youth, that this is an area in dire need of attention. One is also impressed (if not overwhelmed) with the complexity and enormity of the problems involved in trying to overcome the reality and obstacles confronting services to this population. There is no doubt that the challenge is there. The question we must each ask ourselves - are we ready to accept - and push ahead in meeting this challenge.

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SECTION I: THE FAMILY

OVERVIEW: The first paper in this section is that of one of the featured speakers of the conference, Dr. Richard McDowell, on "Working with Parents of Adolescents Identified as Emotionally or Behaviorally Disordered." Dr. McDowell also made a small-group presentation, "The Parents and Siblings of the Severely Emotionally Disturbed: Positive Interaction," as a follow-up to his general session presentation; however, this was not available for inclusion in the Proceedings.

In other papers, autism and the family are discussed. Dr. Sam B. Morgan explores the initial counseling of parents, while William F. Haefele and Dr. Scott W. Henggeler look at autism from a family-ecological systems perspective.

Working with siblings of the handicapped is discussed by Dr. Gwen Benson, and the academic effect of emotional crises on children is the concern of Dr. Jimmie E. Cook. Dr. Gary N. Morrison and Merrie B. Morrison explore the problem of burnout in parents of the emotionally disturbed, while Drs. John G. Greer and Chris E. Wethered look at "learned helplessness" from a family perspective. The final presentation in this section, by Dr. Theron M. Covin, emphasizes the role of mental health in the ministry of the church.

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WORKING WITH PARENTS OF ADOLESCENTS IDENTIFIED AS EMOTIONALLY OR BEHAVIORALLY DISORDERED

Much has been written about the psychology of adolescence. For the most part, these materials have attempted to identify and explain the changes that are experienced and demonstrated by youth as they pass through the "teen" years. Very little has been done to provide parents any assistance in preparing for or coping with the adolescent and his behavior. This may be due in part to many professionals that are either unsure of what to suggest or don't know what to suggest. Others make general statements to the effect that if you give it (the problem) time, it will go away. Many parents of adolescents live their lives waiting for things to change. Time will change many things but it does little to reduce the immediate stress and concern felt by parents when trying to cope with strained relationships or situational crises. One parent stated the problem very well when she told a young psychologist that "until you've lived with one (an adolescent) day after day, you don't know anything." This may well be a correct observation. Personal crises in adolescence are constantly changing. General recommendations as to what to do are usually of little help. Parents must be provided with information and skills that will allow them to interact successfully with their adolescent on both a long term and a short term basis.

Parents should be trained to recognize developmental change, to provide subtle guidance, to maintain open communication, and to support or reinforce the behavioral alternatives they believe to be appropriate and beneficial to the adolescent. Parents and professionals may recognize that an adolescent's striving for independence is normal but they may not know how to respond to specific adolescent acts geared toward achieving independence. They may not know how to give the adolescent room to grow up. The extremes of letting go too much or over controlling the situation may create problems for the adolescent, who may respond with behaviors which go beyond the established limits. A consideration that should be remembered is that no matter how deviant an adolescent's behavior might be, it is their attempt to select the best alternative to meet the situation as they see it. Their behavior represents an effort to resolve some conflict or to bring about certain consequences.

To successfully cope with and negotiate this stage called adolescence parents need to be informed about what to expect. It obviously is not enough to simply have been an adolescent. Our memories are very selective regarding our personal experiences. Many times our memories are distorted to make them fit how we wanted them to be rather than how they were in reality. It is important then that parents be aware of normal crisis or stress points that have the potential of becoming major problems to the adolescent as well as to the parents. The adolescent who is suffering from an emotional or behavioral disorder may experience an aggravation of their condition as they are faced with situations which produce these normal crises.

The adolescent, regardless of his emotional stability, is faced with societal expectations which create a difficult situation at best. In our society the adolescent is neither a child nor an adult. The adolescent is expected to behave as an adult and to leave childish ways behind. But our society has not established any criteria or point of demarcation from which a youth is able to determine that he is no longer a child and has been accepted as an adult. The adolescent is expected to behave and function as an adult but is allowed few, if any, of the privileges that come from being an adult. The uncertainty created by these mixed signals introduces a certain amount of stress in all adolescents. In fact, if we were to use behavior variance as a criteria for emotional or behavioral problems almost every adolescent could be considered disturbed to some extent at various times. Behavior which is unusual or which goes beyond accepted limits has become a hallmark of adolescence. This is not to say that all youth have a difficult time negotiating this stage called adolescence. Some youth seem to have little difficulty while for others it is a time of major problems. If parents know what to expect they may be able to help reduce the stress the adolescent experiences.

There are seven major potential areas of conflict that all adolescents must resolve to at least some degree. Parents, if they understand that these areas of potential conflict, can do much to lessen their impact and the accompanying stress. Each of these areas is a psychological/sociological change that is expected to occur during adolescence. They go beyond but do include the physical changes that each adolescent experiences in the process of growing up. It is not intended to exclude physical change as a potential trouble spot. For many youth these changes can be extremely painful. Parents can help by preparing the youth for these changes. Through discussion (open communication as a two way process) parents can share information and answer questions and concerns the youth might have. This information should not be left to chance since much misinformation is perpetuated by adolescents sharing with each other.

The areas identified as psychological/sociological change are status, identity, independence, relationships, sex, values and decision-making. Each of these require the adolescent to revise his position toward a more adult oriented standard. It must be remembered that although these areas are presented individually, they may be interwoven with each other. (1) Status. Every adolescent is concerned with his or her status in some group. The questions are..."Where do I fit in the group?" and "What is my role in the group?" Knowing their status in a group helps the adolescent define relationships and develop an estimate of self-worth. Status can range from "excellent student" to "star athlete" to "dependable person" to "class clown" to "class bully." The value of each of these descriptors must be found in the perceptions of the adolescent involved as well as within the particular group. Each descriptor can carry either a positive or a negative value depending upon the perception of the individual or the group. Adults cannot rely upon their own perceptions of how it should be by their standards. It is the group's standards that are important to the adolescent. If the status taken on or accepted by the adolescent is in conflict with adult standards, parents and/or professionals can try to help the adolescent understand that he is paying too heavily or that the natural consequences may be too negative for whatever gains he might be receiving from that particular status role. Help adolescents choose realistic status goals that are efficient and will pay-off over the long term. (2) Identity. This area relates to a personal sense of identity. "Who am I?" or "How shall I be known?" Glasser (1972) has suggested that we have been experiencing a shift in the relative importance of role versus goal in our society. Previously in our society (prior to 1960) the primary concern for a majority of our population was financial and physical survival. The "Depression" of the 1930's and the Second World War created an atmosphere in which a person needed to be goal oriented to survive. That is, the individual was willing to work toward goals that would provide an accepted level of security. Once these goals had been reached and the security obtained, the individual could then focus their energy on a particular role. Today, because of a certain amount of economic affluence brought about by mass social programs developed over the last 30 years, youth have developed an attitude of "first I want to find out who I am (role) and then I'll work for some goal." This reversal of the old order of "goal then role" to "role then goal" has placed parents in the position of not understanding their children. In reality, it is not that the parents don't understand their children but rather that the parent views the situation from a "goal" orientation while the adolescent views the same situation from a "role" orientation. In order to interact successfully with the adolescent, the parent must accept the adolescent as a worthwhile person and do so in ways that demonstrate an honest concern and support. Parents can provide opportunities for the adolescent to develop reasoning and decision-making skills, to allow for the selection of alternatives, to develop responsibility, and to gain and demonstrate achievement. An adolescent's identity should help him know who he is, what he represents, what he believes in, and to be able to differentiate self from others. (3) Independence. This area usually creates a considerable amount of stress for most parents. It includes all of the adolescent's attempts at becoming self-sufficient. It is during this process that rules are challenged, that the adolescent responds to parents as if they didn't know what they were talking about, and the adolescent wants to decide things that effect him directly. The rebellion aspect of this process can be dealt with by parents and with less trauma if the parents recognize that it is going to occur and that they allow for a gradual shift from dependence to independence before major conflicts develop. Also, the parent must remember that they are the adult authority and that final responsibility lies with them. Adolescents don't want the removal of all restrictions; they simply need to test them and to seek the revision of some at appropriate times. Parents who are too strict or who provide too much freedom establish the necessary conditions for conflict to develop. Respond to the adolescent as a considerate, intelligent, and caring person rather than responding emotionally. Responding emotionally sets up a confrontation between "my feelings" and "your feelings." In other words, it becomes a personal struggle to protect self rather than resolving issues. Parents should not wait until their child becomes an adolescent to work on independence. The child should have been provided the opportunity to develop these skills at an earlier age and allowed to exercise them within appropriate reason at various ages. Self-sufficiency is necessary to function successfully in our society. (4) Relationships. The type and quality of relationships change dramatically as we grow from childhood to adulthood. It is during adolescence that adult relationships come into focus. The expectations of one's role in a relationship is the major shift. Problems sometimes arise when the adolescent attempts to take on an adult role in a relationship and the involved adults are not ready to allow that to happen. Other problems occur when an adolescent tries on an adult role but doesn't know exactly what to do. Parents can be a big help by helping the adolescent learn the appropriate skills and thus increase the likelihood that the adolescent will be successful in his attempts at behaving in a more adult manner. (5) Sex. Adolescents become very aware of their maleness and femaleness. Physical changes serve as a constant reminder of what they are or are becoming. Sexuality is an extension of one's identity. Situations that interfere with the establishment of one's sexuality can be a source of great psychological stress. A good, solid foundation of information about anatomy, sexual functioning, and the psychological changes that will occur should help most adolescents work through this area successfully. Adolescents need accurate information about such topics as masturbation, petting, sexual intercourse, pregnancy, and venereal disease. This information should be provided in the home. However, some parents may not have accurate information or may not be comfortable in sharing it with their child. Schools then, may have some responsibility in providing this information. Parents need to be aware that the attitudes children learn from the home will, in all probability, be the ones they will keep throughout their lifetime. (6) Values. Each generation is accused of rejecting the values of the previous generation. Standards for behavior are challenged as a part of establishing identity and independence. Adolescents are looking for something to believe in, to invest of themselves in, and to defend. One way to do this is to reject old values and to look for new ones. The painful part of this process for parents is that it is usually the values of the parents that are rejected by the adolescent. Such things as religion, family traditions, and social customs are typically prime targets. If parents maintain their position on these issues they demonstrate to the adolescent the strength of their beliefs and convictions. This is not to say that these issues are not up for discussion. Parents should be willing to discuss (not lecture) these issues with their child. One comforting thought for parents is that a majority of adolescents who have rejected parental values during adolescence return to them when they become adults. (7) Decision-making. Our society places a high value on one's ability to recognize and select alternatives. Decision-making and problem solving are skills that need to be taught to children. This teaching should begin at an early age so that by the time the child reaches adolescence, he has the tools to make appropriate decisions. Allowing a child the opportunity to make decisions and to problem solve not only allows them to exercise those skills but helps to develop their self-confidence. Confidence in one's ability to make wise decisions reduces their fear of failure and increases the likelihood that they will be successful.

The most effective technique a parent can possess that will be helpful is assisting the adolescent to successfully manage these areas of potential crisis is communication. Communication is a two way process, that is, you convey ideas by speaking and you hear ideas by listening. It is effective only when you do both well. Wagonseller and McDowell (1982) in their program "Teaching Involved Parenting" have identified a number of factors essential to effective communication. Such factors as the appropriate use of descriptive praise, constructive criticism, non-verbal messages, listening skills, and a caring attitude in listening are vital to a successful relationship between parent and adolescent.

Professionals working with parents have access to a variety of commercially available materials which are excellent foundations for their groups. Programs such as "Teaching Involved Parenting" by Wagonseller and McDowell (Research Press, Champaign, Ill., 1982); "Systematic Training for Effective Parenting" by Dinkmeyer and McKay (American Guidance Service, Inc., Circle Pines, Minn., 1976); "Managing Behavior: A Program for Parent Involvement" by McDowell

(Research Press, Champaign, Ill., 1978); "The Art of Parenting" by Wagonseller, Burnett, Salzberg and Burnett (Research Press, Champaign, Ill., 1977); and "You and Your Child" by Wagonseller and McDowell (Research Press, Champaign, Ill., 1979) are most helpful in designing, organizing and conducting parent training programs.

When working with parents professionals should remember:

1. Parents have little, if any, training in being a parent.
2. Parents may lack the knowledge or experience to effectively deal with certain situations.
3. All of us have our weaknesses.
4. Help parents correctly identify their assets.
5. Everyone has their down days.
6. All parents experience times of futility and dejection.
7. All parents experience instances of frustration.
8. Crisis occurs in all families.
9. Positive efforts toward effective change can be made when good communication has been established.
10. Situations do occur which interfere with our working together.
11. Use an appropriate format to present information.
12. Everyone needs the right incentive to get started.
13. Each individual family member has their own needs.
14. Be a good helper - provide support.
15. Things do change.

Professionals should help parents to respect the individual worth of the child. They need to become actively involved with their child in a supportive way. This helps the child to know that someone does care and is willing to help. Parents must learn to become consistent in their relationship and interactions with their child. The adolescent needs to know that they can rely on their parents and that they can find support and security there. Teach the child to recognize and wisely select alternatives. The child learns to trust you and what you say when you follow through on commitments you make to the child. To the adolescent this element of trust is of extreme importance. Actions do speak louder than words but words are important too, especially when they are consistent with actions.

Professionals can be of great assistance to parents if they will quit treating them and their children as damaged goods. Treat them with respect. Learn to listen (verbally and non-verbally) and hear what is being said. You are needed for information, for training, and more importantly, for support. Become involved, it pays off for the parent, for the adolescent, and for yourself.

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Understanding the Diagnosis of Autism:
Initial Counseling of Parents and Other Family Members

Sam B. Morgan

One of the most substantial responsibilities of the professional working with developmentally disabled children is the counseling of parents and other family members after the initial diagnosis is made. Because of its extreme complexity, autism presents a special set of problems in such counseling. Although they may have extensive training in certain diagnostic techniques, many professionals are inadequately prepared in effective methods of helping parents understand what autism means for their child and the family. The task becomes even more complicated in interdisciplinary settings where a number of staff members with diverse degrees of experience and training in autism may be involved in the diagnostic evaluation of the child and subsequent counseling of the parents. In training settings, the trainee (e.g., pediatric resident, psychology intern, special education student) might find himself or herself participating in the initial counseling session with inadequate training or experience, often leaving the parents befuddled and frustrated.

Parents justifiably consider the informing interview the culmination of an often lengthy search for answers to questions they have about their child. Many have gone from one specialist to another to be bedazzled by a variety of labels, such as "mentally retarded", "emotionally disturbed", "brain damaged", "aphasic", or "atypical". Then, when their child is finally diagnosed as autistic, they naturally want professional help in understanding the problem and assuring that the child gets the most effective treatment program. The parents have a right to know what the evaluation reveals about their child's abilities, problems, and potential; professionals, in turn, have the responsibility to communicate the evaluation results and recommendations in understandable and usable terms.

Instead of receiving sympathetic help, however, parents of an autistic child sometimes find themselves the victims of certain a priori assumptions held by many professionals--assumptions about their own personality and its crucial role in causation of autism. These parents have discovered that many professionals tend to assume automatically that if a disorder has strong "emotional" components then it is necessarily the result of a disturbed social environment, particularly the environment provided by the mother in the first years of the child's life. In his excellent article on counseling parents of the autistic child, Schopler (1976) refers to these "myth beliefs" about child rearing, beliefs perpetuated in our society by professionals whose conclusions are based more on theory than empirical evidence. Fortunately, within the past decade or so, research has changed our thinking about the nature and cause of autism; and professionals should be familiar with these changes before attempting to counsel parents.

In this paper I offer some guidelines for counseling parents whose child has been diagnosed as autistic. While the paper focuses on the initial informing interview, much of the material also applies to follow-up counseling of parents and other family members. Before presenting these guidelines, however, it seems appropriate to discuss two preliminary topics that bear upon counseling: the need for careful diagnosis of autism; and changes in thinking regarding autism that have occurred during recent years.

Need for Careful Diagnosis

Unless a careful diagnostic assessment has determined that the child meets the criteria for autism, the diagnosis, of course, should not be conveyed to the parents. The symptoms of autism may appear in different degrees and combinations in children with other disorders and handicaps. These children, while failing to show the full constellation of symptoms, might be classified as autistic on the basis of one or two isolated features (for a detailed discussion of this problem, see Morgan, 1981). Further, the terms "autism" and "autistic" have come into such vogue in recent years and have been bandied so glibly in professional circles that many clinicians are probably primed to jump to hasty conclusions and apply the diagnosis too readily. Leading scholars in the area of autism, such as Kanner (1969), Rimland (1971), and Wing (1976), have strongly urged that the diagnosis of autism be carefully determined. They think that parents have been misled, treatment misguided, and research issues clouded by indiscriminate use of the term "autism" and by lumping it with other conditions that may show overlapping symptoms.

The lack of agreement in the diagnosis of autism is, of course, related to the diversity of definitions used by diagnosticians. Clinicians may differ widely in the criteria they use in determining whether a child is to be diagnosed as autistic. Freeman (1977) and Freeman and Ritvo (1977) have done comprehensive reviews of the different diagnostic systems and have discussed the confusion involved in their use. Some researchers have attempted to alleviate some of the confusion by developing objective checklists and rating scales of symptoms and behavior. Rimland (1964), for example, has developed a detailed diagnostic checklist that has been used extensively in research on autism. This checklist, however, may be too lengthy for typical clinical use. A more practical scale has been developed by Schopler and his associates with the TEACCH program in North Carolina (Reichler & Schopler, 1976). The procedure, called the Childhood Autism Rating Scale, provides a structured basis for evaluating the child's behavior and yields a psycho-educational profile of the child's functioning that can be used for treatment and education.

For initial diagnosis in clinical settings, perhaps the most widely used and accepted set of criteria for autism are those outlined in the recently published DSM-III (Diagnostic and Statistical Manual of Mental Disorders, 1980). This manual lists autism under the general category of pervasive developmental disorders; these disorders, which consist mainly of what has previously been called childhood psychoses, are characterized by marked distortions in the timing, rate, and sequence of many basic psychological functions. The DSM-III definition specifies the following six criteria for infantile autism:

> (a) onset before thirty months of age; (b) pervasive lack of responsiveness to other people (autism); (c) gross deficits in language development; (d) if speech is present, peculiar speech patterns . . .; (e) bizarre responses to various aspects of the environment; e.g., resistance to change, peculiar interest in or attachments to animate or inanimate objects; (f) absence of delusions, hallucinations, loosening of associations, and incoherence as in schizophrenia (pp. 89-90).

Because autism is an exceptionally complicated disorder, an interdisciplinary team of specialists is often required for a complete assessment, which should cover physical, social, and psychological dimensions. A physician, such as child psychiatrist, pediatrician, or pediatric neurologist, should be involved to assess the medical aspects. A social worker or related specialist should do a careful study of the social history and family milieu. A psychologist should conduct a thorough evaluation of the child's cognitive and behavioral functioning. Other specialists, such as speech pathologists and educational diagnosticians, can often contribute to the assessment.

Recent Changes in Thinking about Autism

In preparing for counseling of parents of the autistic child, one should be familiar with the changes in thinking about autism that have been prompted by recent research. An understanding of these changes is critical to conveying the nature of the disorder to parents, responding to their questions, and dealing with their emotional reactions, such as guilt.

Until the 1970s autism was still regarded by many professionals as a psychogenic emotional disorder which secondarily affects cognitive functioning. During the 1970s, however, some substantial changes in thinking emerged regarding autism--changes which cast a different light on the cause and basic nature of the disorder. First, more and more evidence suggests that autism is more consistently associated with organic rather than psychosocial variables (DeMyer, Hingtgen, & Jackson, 1981; Piggott, 1979; Rutter & Schopler, 1978). Second, in the eyes of most researchers, autism is no longer viewed as an emotional disorder but as a developmental disorder. As noted above, the DSM-III (Diagnostic and Statistical Manual of Mental Disorders, 1980) categorizes autism as a pervasive developmental disorder; further, the U.S. Office of Special Education has recently moved autism from the "severely emotionally disturbed" category to a special category (National Society for Autistic Children, 1980). Also reflecting this increasing developmental emphasis was the 1979 change in the title of the Journal of Autism and Childhood Schizophrenia to the Journal of Autism and Developmental Disorders. Third, a growing body of research suggests that the cognitive impairment in autism is at least as basic as the affective disturbance (DeMyer, et al., 1981; Morgan, in press).

The changes just noted reflect a definite shift toward the view that autism is a developmental disorder in which cognitive variables play a crucial role. Other changes relate to the alterations in the definition of autism that have evolved since Kanner's (1943) original formulation of the syndrome. Despite the intensive research scrutiny to which autism has been subjected over the years, Kanner's original behavioral syndrome has survived in fairly intact form. The changes in definition that have emerged relate more to Kanner's inferences about the disorder than to his actual description of behavior. The major alteration, based on long-term research with autistic individuals, concerns Kanner's inference that autistic children have "good cognitive potentialities" (Kanner, 1943). Another change involves the assumption that autistic children are neurologically sound, an assumption that led to the exclusion of children with known brain damage from the diagnostic category even though all behavioral features of autism were present.

The two assumptions regarding potentially normal intelligence and absence of brain damage have been until recently implicit criteria in the diagnosis of autism. However, recent definitions of autism, such as those offered in the DSM-III and by the National Society of Autistic Children (Ritvo & Freeman, 1977), make no reference to normal intelligence or the absence of neuropathology. Autism is assumed to occur at all levels of intelligence with or without demonstrable organic pathology. In short, autism can co-exist with mental retardation and organic conditions.

The exclusion of any stipulation of normal cognitive functioning is based on long-term research which indicates that most autistic individuals display substantial cognitive impairment that persists throughout their lives (Morgan, in press). A number of investigations have shown that although the level of functional intelligence may vary greatly in autistic children, most function within the retarded range (Bartak & Rutter, 1976; DeMyer, 1976; Rutter, Bartak, & Newman, 1971). About 60% of autistic children have IQs below 50; 20% fall between 50 and 70; and only 20% have IQs of 70 or higher (Ritvo & Freeman, 1977). Further, mounting evidence indicates that the intellectual level remains stable throughout the lives of most autistic individuals, with about 66 to 75% continuing to function at retarded levels (Ornitz & Ritvo, 1976; Rutter, Greenfeld,

& Lockyer, 1967).

Although many autistic children may present no demonstrable organic pathology, it has been shown that the behavioral syndrome will develop from a number of diverse neuropathological conditions such as phenylketonuria, congenital rubella, tuberous sclerosis, lead intoxication, and congenital syphilis (Piggott, 1979; Rutter, 1979). Further, recent studies have reported more signs of neurological dysfunction in autistic children than were noted in earlier studies; in fact, these dysfunctions become more apparent as the children grow older, even in those children who originally showed no such problems (Creak, 1963; Rutter, 1970; Wing, 1976). For example, the percent of these children who have abnormal EEGs is significantly higher than once suspected. As they grow older and enter adolescence and adulthood, about one-fourth or more develop convulsive or seizure disorders (Rutter, 1970). Although most autistic children exhibit no gross neurological problems, many may show one or more so-called "soft" neurological signs such as incoordination, reflex anomalies, strabismus ("cross-eye"), or poor muscle tone (Ornitz & Ritvo, 1976).

These recent changes in thinking about autism should be kept in mind by the counselor as he or she helps the parents gain a realistic understanding of the disorder.

Conveying an Understanding of Autism

In order to facilitate the parents' understanding of autism and to enlist their vital aid in the treatment of the child, the counselor must first offer the parents help and understanding. Rather than implicating the parents, intensifying their guilt, and recommending therapy for their presumed personality problems, the professional should provide realistic information, practical guidance, and supportive counseling to help the parents in rearing their autistic child.

If at all possible, plans should be made to discuss the diagnosis of autism with both parents together. This avoids the problem of one parent having to assume the responsibility for interpreting complex findings to the other and for dealing with the initial reactions of the other. This also gives the parents opportunity to provide mutual support when presented with sometimes disturbing information. The counselor can also observe the interaction between the parents within the stressful situation of being faced with the diagnosis of autism in their child. In some cases, it might be appropriate or even desirable to include in the informing session other family members, such as siblings and grandparents, or to schedule later sessions for them.

In interdisciplinary settings the informing session usually involves more than one of the members of the diagnostic team. Selection of representatives from appropriate disciplines is important in planning the session and should be relevant to the child's problems. Each discipline has certain primary areas of expertise that may apply to a given child. If there are significant physical findings and recommendations regarding medication, for example, a physician should be involved; if there are anticipated questions regarding cognitive strengths and weaknesses, a psychologist should participate, and so on. The members of the informing team, despite differences in basic areas of expertise, share the common task of communicating to the parents what the diagnosis of autism means in a particular child.

There is a danger of having too many persons participating in the informing session; the parents may feel threatened or overwhelmed by the number of people and diversity of information. In most cases, two members of the diagnostic team can handle the interview quite well if their selection is carefully based on the individual findings and needs of the given case. If there is a great deal of specialized information requiring various professionals to talk with the parents, additional sessions might be held.

Interpretation of autism to parents should be both realistic and cautious. Autistic children represent different measures and blends of symptoms, and each child is an individual with a unique set of behavioral traits even though he shares common symptoms with other autistic children. Terms like "autist" (a noun used to refer to an autistic individual)should be avoided since they naturally offend parents. Such a term presents the child as a label or diagnostic entity, thereby destroying the child's individuality. Although the terms "autistic" or "autism" should certainly be used if the child fits the criteria, the counselor should strive to present the child as a unique person who happens to have autism.

Autistic children vary widely in the degree and type of symptomatology presented. One child may be able to speak, while another may be mute; one may show an intense resistance to change while another may be only mildly upset with change; and so on. A rating scale of autistic behavior, such as the TEACCH Childhood Autism Rating Scale (Reichler & Schopler, 1976),can serve as the basis for interpreting to the parents the particular profile of autistic behaviors presented by their child. The prime feature of autism--the one that distinguishes it most saliently from other developmental disorders and that most disturbs the parents--is the inability to relate to others and to form affectionate relationships. Parents often blame themselves for this problem since it appears to be social and emotional in nature. They should be assured from the start that they are not responsible for the child's apparent refusal to interact with the world.

The other problems presented by the child, problems that are frustrating and baffling to the parents, should be interpreted as part of the syndrome of autism. These include the bizarre responses to the environment, insistence on sameness, attachments to objects, deficient and unusual language, and so forth. Parents often gain some reassurance and comfort in being told that other autistic children show the same inexplicable and unsettling behaviors and that other parents have to cope with many of the same problems.

Cognitive and Adaptive Functioning of the Child

One of the most difficult tasks of the informing interview is giving the parents a comprehensive interpretation of the child's level of functioning in cognitive and adaptive areas. Parents often think that the cognitive impairment is only temporary and once the other behavioral and emotional problems are improved, the child will suddenly become normal. They understandably question the validity of the formal tests of intelligence with their child. This misconception should be addressed at the start by tactfully telling the parents that the measures of intelligence (assuming, of course, that reliable measures are obtained) are usually valid representations of the autistic child's cognitive functioning (Rutter, 1979). The parent often argues that the low performance of the child stems primarily from negativism rather than from in intrinsic cognitive defect. Although negativism and inattention certainly can lower the performance of a given autistic child, they don't play as significant a role in altering performance as parents think they do. Often the child does not perform because the tasks are too difficult. Studies have shown that a valid evaluation of even the most "untestable" autistic children can be accomplished if they are approached with tests appropriate to their developmental level.

Parents often find the low scores on cognitive measures shattering to the illusions that they entertain about the autistic child's "true" intelligence. They often overestimate the child's intellectual potential because he may have shown normal early motor development or even early speech; he may also demonstrate certain isolated abilities, usually in rote memory and visual-motor abilities. The parents should be cautioned that these abilities are misleading and should not be equated with general intelligence. The abilities that the autistic child is most deficient in--conceptual, reasoning, and language skills--are those that are most critical to intellectual functioning and adaptation to life.

Despite their misconceptions about the autistic child's "true" intelligence or potential, parents of autistic children, as Schopler (1976) has noted, can often estimate accurately their child's level of functioning in social, cognitive, motor, and self-help areas. However, they frequently fail to realize the long-range implications of their child's impairment in these areas. In opening the discussion about the child's level of functioning, it often "breaks the ice" to have the parents estimate the child's overall level of functioning in terms of developmental age as well as performance in specific areas. This estimate can provide a starting point for discussion of the evaluative findings.

The findings should be presented in terms that facilitate understanding of the child's general level of cognitive or intellectual functioning, specific strengths and weaknesses, and probable educational and vocational potential. Certain terms glibly used by professionals to convey the child's general level of cognitive development and functioning are meaningless to most parents. To say that their child is functioning within the "moderately retarded" or "severely retarded" range is not very comprehensible to most parents nor is it initially acceptable to them to think of their child as retarded.

In trying to gain an understanding of their child's general level of cognitive functioning, parents frequently want to know the child's IQ. While IQ scores can be useful to the professional in evaluating the child's functioning, for most parents they have no valid meaning since the parents usually do not understand the statistical assumptions necessary for interpretation of a given IQ. Further, there is a tendency for many parents to view the IQ as a fixed, infallible index. In most cases, the professional can give the parents an understandable picture of the child's functioning without reference to the specific IQ score. Some parents, however, insist on knowing the score, and they have a right to know it; the professional, though, has the responsibility to assure that the parents understand what the IQ means and what its limitations are. The parents should be told that the child's level of functioning is not determined solely by an IQ test and that other observations and reports on behavior (e.g., developmental accomplishments, adaptive skills, educational achievement) are also considered. Parents should also understand that IQs vary from time to time and from test to test, depending on the reliability and validity of the particular test.

If age scores, such as the Stanford-Binet Mental Age (for intellectual functioning) and the Vineland Social Age (for adaptive and social functioning), are interpreted with caution, they can be useful in helping parents understand the degree of retardation in their child. These should not, however, be presented as precise scores but rather as approximations and ranges ("Johnny is functioning in many ways at about the level of an average four-year-old.") It should also be stressed that the mental age or social age represents an average of many abilities and skills, some of which may be relatively high or relatively low. Further, it should be explained that the discrepancy between mental age and chronological age usually increases proportionately as the child grows to adulthood. The child whose mental age is two years below his chronological age at four years will likely have a mental age four years below his chronological age at eight years. Parents can relate mental age approximations to concrete behavioral accomplishments of normal children at certain ages.

Often a general level of cognitive and adaptive functioning is given to the parents without further specification. The autistic child, like any other child, has relative strengths and weaknesses which parents should appreciate in order to effectively deal with and plan realistically for the child. The typical autistic child is relatively good in visual-motor, spatial, and memory skills but quite deficient in conceptual and language skills. This pattern, however, certainly does not hold for all autistic children. The person presenting the findings should attempt to convey the child's own unique profile of strengths and weaknesses. In interpreting the child's relative skills, the informant can make the parents feel less threatened and more receptive by starting on a positive note.

Age scores are preferable to standard scores in presenting a differential picture of the child's abilities. For example, parents can readily understand the statement, "Johnny is about like an average six-year-old in motor skills but his language skills are at about the level of a three-year-old." As noted above, parents often place too much emphasis on isolated skills and do not understand what significance they may or may not have for long-term adjustment. The professional should stress to them that language and conceptual skills are much more potent predictors of later functioning than are visual-motor and memory skills.

The autistic child might also show significant variability in academic skills. Grade scores are probably the most easily understood indices since they provide concrete points of reference for most parents. Caution should be exerted, however, in interpreting the seemingly precocious reading skills demonstrated by some autistic children since parents tend to surmise that these indicate high intellectual potential (Cobrinik, 1974; Morgan, 1981; Rimland, 1964). In most cases, these reading skills represent rote perceptual analysis and are unaccompanied by any apparent comprehension. Cobrinik (1974) has explained these rote reading skills on the basis of the isolated facility for pattern recognition that many autistic children have. To these children, words may merely represent complex spatial patterns that are instantaneously processed like subway maps.

The parents should be cautioned against viewing the indices reflecting the child's current level of functioning as limiting factors for behavioral change. For this reason, it is helpful to discuss in behavioral terms what the child can do in certain areas and what he might be realistically expected to do. It should be stressed to them that, although the child is autistic and has cognitive impairments, with effective educational and behavioral management techniques, he can learn to function higher in certain areas, especially in self-help skills.

The parents should also understand that the evaluation is an ongoing process that should not end with the initial diagnostic study. In most cases, especially with young children, periodic re-evaluations will be needed to assess progress in certain areas as the child grows older.

Long-Range Expectations

Parents always want to know what the future holds for the child, that is, what they can expect from the child in terms of long-range educational and vocational accomplishments and adaptation to life. Reliable answers to these questions about long-range expectations are difficult to provide. The only basis for answers is the available information we have on autistic individuals who have already reached adolescence and adulthood. From such data we try to determine those characteristics that appear to be associated with long-term improvement and adjustment. These answers, however, should be presented to the parents in tentative terms because many of the individuals studied, especially those who are now adults, did not have the benefit of the intensive early treatment and educational programs now available in some communities.

The parents should be given a cautiously phrased statement regarding prognosis for autistic children. The parents should understand that in most cases autism is a severe, long-term disorder and that the likelihood of an autistic individual achieving completely independent adjustment, even as an adult, is small. A recent review of all follow-up studies on autistic children revealed that only five to seventeen percent of all children eventually achieved a "good outcome", which meant that their social life was near normal and their school or work performance was satisfactory (Lotter, 1978). On the other hand, sixty-one to seventy-four percent of formerly autistic children had "very poor outcomes", which meant that they were incapable of leading any kind of independent life.

The evaluation findings on the child should also be interpreted in light of factors that are associated with later adjustment of the autistic individual. Two of the strongest predictors have to do with language and measured intelligence (Kanner, Rodriguez, & Ashenden, 1972; Lotter, 1978; Morgan, 1981). The use of language for communication before age five or six has been found to be a crucial prognostic sign in most studies. The child who displays some functional speech by this age stands a chance to achieve some adjustment; the child who is mute stands very little chance. The measured intelligence of the young child is also predictive of later functioning. The higher the IQ, the closer the child will approach normal adjustment. The same rule, of course, holds for typically retarded children. While autistic children differ in many respects from most retarded children, it appears that they, too, represent different levels of functional intelligence.

There are other factors related to prognosis that should be kept in mind when helping parents form realistic expectations. Seizures and other signs of neurological dysfunction or damage are correlated with severity of retardation and long-term impairment in autism (Lotter, 1978). The play activity of the child serves as another prognostic sign. If the child plays appropriately with toys before age five or so, the prospects for later adjustment are better (Brown, 1960). The severity of the early symptoms shown by the child also is associated with later adjustment; the more pronounced these symptoms, the lower the response to treatment and educational programs.

In interpreting these prognostic signs to parents, one should try to help the parents achieve a balance between realistic expectations on one hand and strong motivation to improve the child's condition on the other. The factors summarized above should not be presented as final answers to questions of long-term prognosis for the autistic child, nor should they be regarded as infallible predictors of success or failure. If this occurs, we may lead the parents into the web of self-fulfilling prophecies. The five-year-old child with no language and an IQ of less than forty should not be summarily written off as hopeless and relegated to life in an institution. The prophecy that the child will never adjust will, of course, be fulfilled if the parents throw up their hands in hopelessness and never give him a chance in various treatment and educational programs. In fact, it should be emphasized to the parents that one favorable prognostic sign is their willingness to commit themselves to a systematic behavioral program in which they play primary roles (Lovaas, Koegel, Simmons, & Long, 1973). And the earlier such a program is started in the child's life, the better chance he has for later adjustment.

In phrasing predictions, one can be realistic and still show regard for the feelings of the parents. Parents are less likely to be upset by, and more likely to accept, predictions phrased in positive rather than negative terms. The statement, "We feel that Johnny will be able to learn some useful speech and basic self-help skills," is much more palatable and no less realistic than the dismal forecast, "Johnny will never learn high-level language or be fully independent in taking care of himself."

Dealing with Etiological Questions and Reactions to Diagnosis

After being told that their child is autistic, most parents understandably want to know why he is that way. In most cases by far, the cause will not be definitely known, even though extensive diagnostic studies are done. If there appears to be a clear cause (e.g., Rubella syndrone, Fragile X syndrome), then the parents, of course, should be informed of it. Despite the absence of a demonstrable cause, one should assure the parents that most research findings would strongly indicate that the parents are not the causal agents. The parents should be told that although the cause of autism is not clearly known in most cases, there is an overwhelming body of evidence suggesting that it is probably the result of some neurological defect that might be caused in various ways. Assuring the parents that they did not cause the disorder will help them deal more realistically with feelings of responsibility and guilt.

Although etiological factors are certainly important in research and prevention, little is usually accomplished by speculating at length with the parents on possible causes of their child's autism. Once alleviating the parents' guilt by dispelling the notion that they caused the child's condition, the professional can be of greater aid by concentrating on the child's current functioning, the factors that continue to contribute to his handicap, and realistic plans for helping him.

Aside from guilt reactions over their presumed role in causation, parents show a variety of reactions upon being told for the first time that their child is autistic. Many parents respond realistically; others are justifiably defensive. One of the most common initial defenses is that of denial. The parents may openly reject the idea that their child is different, even in the face of overwhelming evidence for autism. Others ostensibly accept the diagnosis but privately cling to the belief that nothing is wrong and that the child will outgrow the problem. In these cases of denial, it will take time and often subsequent counseling before the parents can realistically accept the fact that the child has autism and that it is a severe handicap that will not disappear with time.

The atmosphere of the initial counseling session should be such that the parents feel free to express their feelings and reactions. In addition to guilt and denial, parents may show such reactions as depression, loss of self-esteem, projection of blame to others, and ambivalence. Often the professional presenting the diagnosis becomes the target of the parents' frustrations and pent-up anger over previous experiences with professionals. Such reactions should be viewed as natural and not taken as personal affronts. In an acceptant atmosphere, the parents' feelings can be recognized and openly dealt with to avoid later difficulty, and the need for further counseling can be better determined. The encouragement of the expression of feelings, however, should be done with sensitivity and discretion. To some parents, the hearing of the diagnosis and its implications serves as confirmation of what they had suspected or acknowledged all along; and they attempt to accept the findings realistically with few emotional defenses. These parents, while comprehending the findings, might contain their emotions during the informing session. Professionals should accept these reactions as appropriate and should not view the session as a failure if intense feelings are not expressed.

Recommendations for Treatment and Education

In his article on counseling parents of autistic children, Schopler (1976) calls attention to the traditional conflict in roles between professionals and parents--a conflict that interferes with effective treatment of the autistic child. The professional has traditionally assumed the role of the "authority", giving the "expert" knowledge but remaining detached from the responsibility for the child's day-to-day problems. In contrast, the parents have traditionally had the responsibility for rearing the child and meeting his everyday needs. Schopler advocates a merger of these two roles. Most parents are experts about their own child and can provide valid and useful information to the professional. They can also contribute actively to the treatment and education of the child, instead of leaving such functions completely in the professional's hands. The professional, in turn, should share some of the responsibility and "accountability" for the child's overall welfare and should work to assure that appropriate treatment and special educational programs are available in the community.

Regardless of the amount of specialized attention given the autistic child by professionals, any treatment or educational program is futile without the cooperation and involvement of the parents. As noted above, those autistic children who show the most lasting and generalized benefit from behavior modification programs are those whose parents are willing to apply treatment at home. Further, such home treatment is much more effective in improving the child's behavior if it begins when the child is quite young. Rather than being excluded from treatment programs, then, parents are becoming more and more the primary therapists for their child.

The professional has the responsibility to provide current information on the effectiveness of various treatment and educational programs available to autistic children and their parents. Despite the claims of the more ardent practitioners of different therapies, there appears to be no "cure" for autism. The parents should be cautioned about treatment programs that offer quick cures or substantial improvement through special diets and so forth. Such claims offer false hopes to parents who are often desperate and vulnerable to exploitation. One should be prepared, then, to respond to questions about these approaches and should share information based on current research.

Questions are often asked about the effectiveness of drugs and special diets in the treatment of autism. Although a number of different drugs have been tried, none has eliminated the basic symptoms of autism. Some, however, have been helpful in partially controlling some of the problems sometimes found in autistic children, such as hyperactivity, distractibility, stereotypic behavior, and sleep disturbances (Campbell, Geller, & Cohen, 1977; Ornitz & Ritvo, 1976). These drugs generally are employed when behavioral treatment has proven to be ineffective by itself; in all cases, drug therapy should be recommended only as an adjunct to other treatment programs.

Parents are drawn, too, toward special diets or vitamin therapy for the child. Although some researchers (e.g., Rimland, Callaway, & Dreyfus, 1978) have reported that some autistic children, particularly the classically autistic ones, show improvement in behavior with high doses of single or multiple vitamins, the results are still far from conclusive; and further research is needed to establish the effectiveness of such treatment. Too often, parents initially view these approaches as panaceas but later are severely disappointed with the outcomes.

Parents should also be informed that traditional psychoanalytic and "play therapy" approaches have been ineffective in the treatment of autism. In fact, such approaches are not at all correlated with later adjustment and consume time and effort that could be directed toward more productive programs.

By far the most effective treatment programs that can be offered are those that flexibly incorporate recent research findings and proven techniques into a comprehensive whole--a whole that includes tested principles of behavior modification and special education, parental counseling and participation, useful diagnostic methods, and treatment that pervades the child's total life. For the pre-school autistic child, the application of behavior modification principles by parents has been shown to be effective and enhances later adjustment. It is critical, then, that parents learn behavior management techniques that can be applied at home as early as possible in the child's life. One of the crucial features of parents who are most successful in helping their child is a willingness to apply strong, tangible consequences, such as food and spankings, to the child's behavior (Lovaas, Koegel, Simmons, & Long, 1973). Such parents also reject the notion that their child is "ill"; instead of treating him as a sick person, they place demands on him and are willing to commit a major part of their lives to their child and the daily management of behavior contingencies for him.

Once the child becomes eligible (in some states this is at four or five years of age), the parents should pursue, with the help of the professional, appropriate special educational programs and community based treatment programs. Such programs represent the most effective means of teaching the autistic child adaptive, language, social, and other skills. The TEACCH (Treatment and Education of Autistic and related Communications handicapped CHildren) program in North Carolina is a good example of a program that provides a comprehensive educational and treatment service to autistic children and their parents. Unfortunately, most communities do not have such specialized services for the autistic child. The professional, then, should help the parents in finding the most appropriate special education program available in the community.

The initial informing session usually conveys a substantial amount of diverse information, some of which might be difficult for parents to understand and accept in so short a period of time. Invariably, questions and problems emerge after this session. The professionals conducting the session should assure the parents that they will be available to answer questions and provide follow-up counseling as needed.

During the initial session the parents should be strongly encouraged to join the local Society for Autistic Children (if one is available) and the National Society for Autistic Children (NSAC). The local Society can offer invaluable support to the parents and family as well as furnish useful information on autism. Because of the very special and demanding problems that they confront every day, parents of autistic children often share a deep kinship with one another. Parents who have had experience in rearing an autistic child can usually establish ready rapport with parents coping with the initial diagnosis and can offer effective and realistic support. Membership in a parents' organization will also allow the parents to participate in development of better community facilities for autistic children and in promotion of greater public awareness and acceptance of autism.

In counseling parents, one should consider the impact of the autistic child not only on the parents but on other members of the family and on the family system. Because of urgent demands presented by the typical autistic child, parents sometimes focus all of their attention on him and neglect the needs of their other children. As noted above, counseling of siblings is often necessary to aid them in realistically understanding and accepting their brother's or sister's condition. Further treatment, offered either individually or to the family as a whole, may also be needed to help siblings and other family members deal constructively with their feelings toward the autistic member and his influence on family relationships.

Autism is the most baffling behavior disorder of children. Parents and family of the autistic child have to deal with frustrations that usually exceed those associated with other childhood disorders. Professionals engaged in the diagnosis and evaluation of the autistic child should acknowledge that even the most intensive of studies are of little value unless the parents understand the diagnostic findings and their implications. The same professional concern and thoroughness shown in the evaluation should be applied to the initial counseling of the parents and other family members. Such counseling should help the family take a significant first step toward gaining a better understanding and acceptance of the autistic child in their home.

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Autism: A Family-Ecological Systems Perspective

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Abstract

The autistic child is embedded within several systems including the family, medical system, and school. The interactions of these systems exert strong effects upon the behavior of the child and the other members of these systems. This paper reviews the extant literature and describes the nature of the bidirectional influences among child, family, professional, and school. In contradiction of psychogenic theories of autism, reseachers have observed that the parents of autistic children are not more pathological than the parents of handicapped children. The confusion, frustration, and uncertainty experienced by these parents seem related to the problems presented by their autistic child as well as other systemic variables. Although researchers have rarely evaluated the influence of autism upon the marital relationship and siblings, both beneficial and detrimental outcomes seem feasible. Medical professionals and educators can interact with parents and family members in ways that either reduce stress and help to ameliorate a difficult situation, or exacerbate existing difficulties.

Autism: A Family-Ecological Systems Perspective

During the past 30 years researchers of child psychopathology have shifted their perspectives in recognition of two principles. First, the child is embedded within multiple systems which interact in direct and indirect fashions to influence behavior (Bronfenbrenner, 1979). Second, behavior occurs within relationships that are characterized by reciprocal and bidirectional interactions (Bell, 1968; 1971).

There are several systems that influence and are influenced by the child's behavior. Most important is the family system which includes parent-child subsystems as well as the marital relationship and sibling subsystem. Other pertinent systems include peer groups, neighborhood, schools, and the professionals who interact with the autistic child and his or her family. In addition to the impact of these systems, the interactions between systems influence child behavior. The quality of parent-school relations, for example, may serve to exacerbate or ameliorate maladaptive child behavior. Consideration of interactions within and across systems is necessary in order to more fully understand and appreciate the ramifications of childhood autism.

Behavior is not unidirectional; it is reciprocal and bidirectional in nature. Researchers of child psychopathology have frequently and erroneously attributed child behavior problems to certain parental behaviors. For example, researchers have observed that the parents of aggressive delinquent adolescents are sometimes hostile and rejecting toward their children. From a unidirectional perspective, parental rejection has been posited to cause delinquency. However from a bidirectional perspective, it is equally probable that repeated child noncompliance and obnoxious delinquent behavior caused parental rejection. The family-ecological perspective (Henggeler, 1982) emphasizes the reciprocal nature of such parent-child interactions and attributes behavioral difficulties to the system rather than the child or the parent, per se.

The purpose of this paper is to examine the effects of the autistic child on the systems in which he or she is embedded and upon the interactions between these systems. We focused upon the family, school, and medical/professional systems and identified those factors that are most likely to exacerbate the difficulties posed by the autistic child. Recommendations are made for minimizing the negative effects of autism across systems.

The Family System

Undoubtedly the system most strongly affected by the autistic child is the family. Effects are felt by all family members and family subsystems.

Parent-Child Interactions

Parents, as primary caregivers, have received a great deal of attention from researchers of childhood autism. Traditional clinicians and researchers, employing a unidirectional model of causality, have concluded that parental psychopathology is a major etiological factor in autism (Eisenberg & Kanner, 1956; Goldfarb, 1961; Kanner, 1949). For example, Meyers and Goldfarb (1961) characterized parents of autistic children as passive, uncertain, lacking in spontaneity, bewildered, and unresponsive to socially unacceptable behavior. The authors attributed much of the autistic child's behavior to such parental pathology.

The psychogenic position has been challenged by researchers operating out of two different perspectives. First, there is extensive evidence that the mental health of parents with autistic children does not differ from the mental health of parents with handicapped children (Cantwell, Baker, & Rutter, 1978). Although Goldfarb and his colleagues reported that parents of autistic children are especially psychopathological (Goldfarb, Goldfarb, & Scholl, 1966; Goldfarb, Levy, & Myers, 1972; Goldfarb, Yudkovitch, & Goldfarb, 1973), their findings have not been replicated. Cantwell et al. (1978) suggested that the findings of Goldfarb and his colleagues resulted from methodological inadequacies including poor sampling methods, inappropriate control groups, and the failure to differentiate between autism and other developmental disorders.

A second challenge to the psychogenic view of autism emerges from a growing body of developmental literature, as well as from family system theory. Developmental researchers have demonstrated that individual differences in infants regarding mood, temperament, and regularity, affect parental perceptions of the child and parent-child interactions (Bell, 1968; 1971; Korner, 1971). At birth the autistic child is relatively unresponsive to social stimulation and infrequently reciprocates maternal and paternal overtures. Faced with an unresponsive infant, most parents initially increase their level of stimulation in the hope of prompting increased behavior. However, as the infant continues to withdraw, the parent is naturally confused, perplexed, and may feel rejected and inadequate. Although parents may further increase their efforts to interact with the child, such efforts are doomed to failure. Parents learn that their efforts are not productive and they eventually withdraw and decrease their attempts to elicit responses from the infant. Such parental behavior may appear to be cold and rejecting from an outside perspective several years after birth. However, when viewed within a bidirectional and longitudinal context, parental withdrawal is a natural outcome of a difficult situation.

In summary, the parents of autistic children tend to manifest characteristics that are consistent with those found for parents of children with developmental disorders. Parents might react with confusion, uncertainty, perplexity, frustration, and a general sense of inadequacy. In some cases they will respond to their child with greater than normal nurturance and permissiveness (Wolchik & Harris, 1982). In other cases parents may respond with rigidity and rejection (Goldfarb, 1961). The particular response is a product of several interrelated factors including the individual qualities of the parent, the child's behavior and level of functioning (Goodman Campbell, 1979), parental child-rearing attitudes (Yule, 1975), and the availability of extrafamilial resources.

The Marital and Sibling Subsystems

Although there is growing interest in the effects of autism on parent-child interaction, few efforts have been made to assess the effects of autism upon other family subsystems. It is highly likely that the extreme stress, frustration, time, and financial demands of raising an autistic child impact upon the marital relationship. Successful marriages require joint activities, privacy, relations with extrafamilial social systems, and emotional responsivity. The increased child-rearing burden that typically falls upon the mother may lead to resentments of the husband's apparent freedom. The obvious nature of the autistic child's problems make it difficult to take the child out in public, thus limiting joint family activities. The behavior problems can also make it difficult to find an appropriate babysitter so that the parents can have some time alone.

Moreover, management of the autistic child's behavior problems can become a battleground of marital conflict (Kysar, 1968). On the other hand, for some couples increased stress can enhance their emotional bond. Successfully coping with their child's problems enables them to become more mature, compassionate, and giving. It is essential that researchers begin to address the parameters of both the positive and negative impact that autism exerts upon the marital relationship.

The effects of autism upon the autistic child's siblings have not been evaluated. Normal siblings may resent the amount of attention given to the autistic child by their parents, thus impairing parent-normal child relations. Similarly, siblings may be reluctant to invite playmates to their home, thus impeding peer relations. Siblings may also have greatly increased responsibility to care for their autistic brother or sister, thereby further limiting the development of social relationships. On the other hand, the family may develop in a way that allows siblings to acquire a tolerance for differences among people, compassion, and empathy. Unfortunately, research has not identified those factors which mitigate or exacerbate the effects of living with an autistic sibling. Variables such as severity of the autism, effects on the marital relationship, modeling of attitudes by parents, and the ages of both the sibling and the autistic child likely play a role in the siblings' response.

Family-Medical System Interface

The professional's conceptualization of the etiology of childhood autism significantly influences his or her relations with the child's family (Kysar, 1968). Professionals who hold strong organic perspectives may absolve the parents of responsibility for the child's behavior and inadvertantly fail to make the necessary demands on parents for adequate treatment. Adherence to a psychogenic view may provoke increased parental guilt as well as a devaluation of parental observations and concerns. For example, Zuk's (1959) warning to professionals not to accept parental assessments of their autistic child at face value has probably resulted in an inappropriate distrust of parents by clinicians. Professionals who disregard parental input may unwittingly isolate parents, leaving them discouraged, frustrated, and delaying appropriate interventions. In fact, parents are realistically aware of their autistic child's limitations and rarely distort their assessment in a favorable direction (Kysar, 1968; Schopler & Reichler, 1972). It is important to remember that although the parent might give accurate assessments of the autistic child's behavior, this does not necessarily mean that he or she will understand the implications of this behavior in terms of prognosis and treatment.

Therapeutic interventions are usually a direct function of the theoretical orientation adopted by the professional (Bartak & Rutter, 1973). These interventions become the ongoing basis of the interaction that occurs between the professional and family. Parents generally respond quite favorably to treatment interventions if professionals are sensitive to their impact on family functioning (Kysar, 1968). Professionals who fail to consider the effect of their directives on the parents' feelings, marital relationship, sibling relations, and financial resources, seriously undermine therapeutic goals (Howlin, Marchant, Rutter, Berger, Hersov, & Yale, 1973). However, by directly responding to these systemic issues the professional may enhance treatment efficacy and family functioning.

There is a growing body of research which demonstrates that parents perceive treatments differentially depending upon the behaviors targeted for change, the efforts of the professional, and the congruence between treatment strategies and parental attitudes toward child management. The behaviors targeted for change that have the most impact on the family are those related to improved social skills and reduction of bizarre behavior. Behaviors such as speech, self-stimulation, tantrums, play, and cooperation heavily influence global impressions of autistic children and if these behaviors are modified some negative effects on the family can be alleviated (Schreibman, Koegel, Mills, & Burke, 1981). In addition, specific information regarding child management techniques has been found to favorably impact upon the parents' ability to cope with the difficult situations presented by their autistic child (Gardner, Pearson, Bercovici, & Bricker, 1968).

Demonstrations of the professional's interest, effort, and concern have a positive effect on the family's attitude toward treatment (Holmes, Hemsley, Rickett, & Likierman, 1982; Howlin, et al., 1973). This concern and effort can be demonstrated by a willingness to make home visits (Holmes, et al., 1982), to discuss problem issues such as guilt and resentment and to be sensitive to family functioning (Kysar, 1968). In addition, professionals who explain treatment goals in a manner consistent with the child-rearing attitudes of the parents increase the probability that behavioral changes will be effectively maintained (Yule, 1975).

Finally, professionals who work with families of autistic children must remember that there will certainly be instances when the autistic child does not respond to treatment. In the face of such failure the clinician's sense of professional competence may be threatened and he or she may feel a need to blame someone for the lack of progress. This may lead to the unfortunate displacement of guilt and anger toward the parents and family or even toward the autistic child (Aug & Ables, 1971). In order to minimize frustrations and displacement, professionals need to monitor their emotional response to working with autism as well as the subtle effects of their behavior upon the family.

Family-School System Interface

The school system interacts with the family system in several significant ways. In many cases this relationship is manifestly unidirectional, that is, the school provides programs for the child and information to the parents without considering the family's readiness and ability to carry out the instructions. If parents are overburdened by expectations of the school they may withdraw from school contacts and the school's ability to intervene effectively is reduced. Efforts aimed at systematically increasing positive mutual interactions between school and family are warranted, especially in light of evidence suggesting that manipulation of the school environment to more closely resemble home conditions facilitates generalization of educational gains (Handleman & Harris, 1980).

To facilitate increased reciprocity between home and school, Ruttle (1981) suggested that the school psychologist serve as a liaison and coordinator of treatment efforts. For example, the psychologist would be responsible for on-going assessment, consultation, and support of the educational staff as well as for insuring that parents and teachers are well informed about the autistic child's behavior in both settings (Sloan & Marcus, 1981). The professional might encourage specific activities such as parental observations in the classroom, team planning of treatment strategies, and home visits to observe the efficacy of those strategies. Hopefully, such coordination would increase therapeutic consistency across settings and facilitate the behavioral gains of autistic children (Schopler, Brehm, Kinsbourne, & Reichler, 1971). Moreover, such an approach should enhance parental understanding of treatment procedures and demonstrate a high level of concern on the part of the school. Each of these factors have been shown to contribute to treatment gains and maintenance (Wetzel, Baker, Roney, & Martin, 1966).

Finally, Kelley and Samuels (1977) suggested that schools provide support and discussion groups for the families of autistic children. The efficacy of such groups in terms of reducing isolation, anger, frustration, and guilt has been demonstrated with parents of retarded children (Tavormina, Hampson, & Luscomb, 1976), and the parallels for parents of autistic children are evident. In addition, such groups could be used by the school system as an opportunity for further parent training and refinement of treatment strategies.

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Working with Siblings of Handicapped Children

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ABSTRACT: The purpose of this presentation was to provide teachers, counselors and parents with necessary strategies for working with siblings of handicapped children (mildly, moderately and severely handicapped, developmentally delayed, autistic). In addition, means of recognizing when and if counseling is needed were discussed. Presentation included rationale, development, implementation, and results of a sibling workshop which included thirty siblings of handicapped students. These handicapped students, all of whom were enrolled in a preschool for handicapped children, participated in the second day of the workshop.

This session provided participants with various strategies that can be used when working with siblings of handicapped students. Results of the two-day workshop were presented along with appropriate settings, suggested materials, and pre-and-post tests. Follow-up activities included questions, discussion and distribution of handouts.

Editor's note: Dr. Benson's paper was received too late for inclusion in this portion of the Proceedings; it has therefore been added as Appendix F. We are happy to be able to include it.

CHILDREN IN CRISIS -- THE ACADEMIC EFFECT

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"It would be nice if some writer would get around to describing me as sexy." (Sports Illustrated, March 6, 1972).

Chris Evert, one of the premier tennis players of all time allegedly made the statement despite the fact that she had been described as "brilliant," "cunning," "aggressive," and "millionaire tennis star," at various times during her career. Certainly, enough plaudits for anyone, we might think, but each individual decides what frustrates and therein can be found the beginning of a crisis.

Quite literally, on a day-to-day basis, minor to significant crises occur to each of us and depending upon the intensity or severity, we react accordingly. Our behavior might be a shrug of the shoulder or we might be worthless the rest of the day or longer. One suspects that Ms. Evert was dealing with a "shrug of the shoulder" crisis since she went out and soundly defeated her next opponent after the interview.

Crises of a potentially more dangerous level occur to students that we come into contact with daily and unless we become aware of them and take steps to alleviate the problem, our survey shows that reading in particular and academics in general are affected areas.

The crises we are referring to are not the "shrug of the shoulder" type but a higher, more debilitating kind. We refer to death, divorce, hospitalization, moving from one place to another, and physical, emotional or sexual abuse.

We interviewed 300 students from grades 2-6, 9-12 and college-age who had undergone a crisis during their elementary years such as described above. Our first question to them established the type of crisis that had happened and all of the above were mentioned minimally five times (abuse of one type or another) to divorce (104 cases). Death was second largest as a "crisis causer."

When asked whether or not the particular crisis affected their academic performance, all responded positively that the crisis did interfere with their school work. Of the 100 in grades 9-12 and 100 college students interviewed, eighty-seven indicated that the crisis impact was short-lived and they returned to their usual academic performance while 113 felt that they never returned to the level of prior productivity and they blamed it on the particular incident that occurred.

When queried further, the 87 who reported a short-lived interference noted that they had been helped through the crisis by talking with teachers, parents or friends. They all indicated that they felt someone cared about the situation besides them, and as a consequence, were able to overcome the particular problem. Of further interest at this particular age level, the 87 who felt they overcame the various crises were more articulate in describing their problem and were more eager to discuss the situation. Those who felt they had never overcome the problem were hesitant and required more diligence on the part of the writer to elicit the information. As an example of this, the average session with a student who had overcome a crisis averaged about thirty minutes and those who had not overcome the problem required considerably more interview time (the longest being 10 hours) to get them to discuss the problem.

Fifteen of the 9-12 and college group indicated that a death had occurred in their class while in elementary school and only three felt that their teacher or parent had helped them in the situation. In most cases, the teacher would not allow the class to discuss the situation and nine remarked that the empty chair in the classroom loomed more ominous with each passing day.

Grades 2-6 were still dealing with the crisis that had occurred and most (83) were reluctant to discuss the problem. Of the seventeen who were handling the crisis well, all indicated that teachers, parents and friends discussed it in an open way and helped them think it out. Additionally, the seventeen felt that an adult or peer was ready to talk with them whenever they had a question or problem that was bothering them.

All of those surveyed indicated that reading was affected most, either short-term or long-term. The vast majority indicated that they were too bothered to read or that it was boring or other sundry reasons. Even the few (7) who indicated that all they did was read during the crisis noted that the reading was escapism and they could not recall one thing read during the intense part of the crisis.

The essence of the survey indicates that serious crises have a profound effect on learning in general and reading in particular and since an overwhelming majority felt they had not overcome the loss of interest or ability in reading (56% in grades 9-12 and college, even though the crisis had occurred years before and 87% in grades 2-6 who were presently dealing with the crisis), it is suggested that parents and teachers have not dealt as effectively with the problem as necessary (Cook, Fall, 1982).

It would appear that teachers must become more assertive in dealing with personal problems in their charges (Cook, March, 1982). If a child in the school dies (or a teacher), nothing is gained by ignoring the real fear children feel. We are not suggesting that one become maudlin on the topic but such unspoken questions as "am I next?" or rumors about the cause of death haunt young children and must be dealt with immediately in a rational, yet sensitive way (Cook, November, 1982). Total class discussion and individual questions answered as often as asked later is a proper way of dealing with the topic.

In a more private sense, if a death of a parent, sibling or other close relative occurs, the teacher needs to be finely tuned-in to radical or less obvious changes in a student's behavior when a death happens. Often, just showing you care and are willing to listen is all that is required and if the syndrome persists, other specialists are involved as needed.

Whereas death was an everyday part of our life in yesteryears, it is not so today. Children of even thirty or forty years ago saw the slaughter of animals for food, the death of grandparents who often lived in the home and certainly were "laid out" in the home. Today, young children are not so exposed. The ones who have "passed on" are now "laid out" in some mortuary and many parents feel the need to "protect" their children from reality. From such irrational logic, crises are precipitated. Teachers may have to fill this void.

Much the same can be said about divorce, moving, hospitalization and other incidents which profoundly affect young children. How often have we heard such horrible crises-laden statements as "he comes from a broken-home?" Children hear these statements and they are bewildered. What is a broken-home? Did my house crack open? (Cook & Hoffman Oaks, December, 1979).

Teachers must be prepared for situations such as the above and must ask themselves what steps they would take in the event they become convinced of physical, sexual or emotional abuse of a child. How can I make the impact of moving from one state or school to another easier on my children or what steps should I take to welcome new arrivals to my school? Do local hospitals have educational programs or hospitalization for children (many do and are happy to visit your school)?

Our survey has convinced us that crises can have a permanent effect on young children's academic performance and on reading in particular, and we also believe our role as teacher requires us to do more than deliver the mechanics of the "Three R's." Our reason for mentioning this is that in a survey of thirty-four teachers in elementary classrooms who had been active in a classroom when various crises occurred, a startling twenty-eight indicated that they had not made extra effort on behalf of the victim even though they noticed behavioral changes. When asked why not, all in one form or another responded that they were afraid because they did not know what to do.

Teachers appear no better prepared to deal effectively with crises management than most laymen. Since we are an omnipresent force in a child's life, colleges should be preparing teachers to handle crises from small to large, as it is certain that major disruptions will occur. We must be prepared to meet them. A more detailed description of how teachers might react to various crises is available. Send a self-addressed 9 X 12 envelope with three first-class postage stamps attached to the writer at Department of Education, Lambuth College, Jackson, Tennessee - 38301.

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Burnout in Parents of Emotionally Disturbed Adolescents

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Interactions with the parents of handicapped children can often be trying experiences for many professionals--especially with those parents whose children have reached adolescence. We have all heard the professional who moans, "They just don't seem interested in their child. They won't cooperate with me, and I am trying to help *their* child!" Much of this "lack of cooperation" is simply due to a reaction by the parents to stressors that have been building up for years without relief. The professional who works with these children is able to take periodic vacations and/or change job-locations if the stress-level becomes a problem; and even then, some professionals complain of "burnout." They just do not feel able to handle the stress, and so either quit or, at the least, lose some of their sensitivity. The parent is not allowed to quit, and very rarely is allowed a vacation from the responsibility of raising a disabled child. It is only logical to assume that the level of stress felt by these parents will far surpass that felt by the professional. The constant, day-to-day battle that is fought by these parents can easily lead to a burnout situation that is often mistaken for lack of concern or cooperation (Boggs, 1978; Burke, 1978; Morton, 1978).

STRESSORS

Several of the stressors that are experienced by these parents will be discussed in this article. Care has been taken to try to approach each topic from the perspective of the parent. This is definitely not an exclusive list of topics, although the authors have attempted to identify the major stressors. Those stressors that will be discussed are

1) problems innate with the handicap
2) lack of progress/development
3) public opinion
4) pressures from spouse or other family members
5) pressures from "support groups"
6) loneliness
7) parental death
8) financial needs
9) lack of relief
10) dealing with professionals.

Problems innate with the handicap. This is an extremely variable category. The degree of stress felt by the parent is correlated to some extent by the degree and type of involvement that is present in the child. A child with no self-help skills who is totally dependent upon the parent and who also is unmanageable emotionally will cause quite a bit more strain than will the child who is self-sufficient and controllable. The personality of the parent is also a major factor. Some parents will be able to accept even major handicaps, while other parents can be devastated by what the professional would consider a minor problem (Webster, 1977). Care must be taken to evaluate the effect the specific handicapping condition has upon the particular parent. Individual differences are so extensive that generalizations are useless and can often hamper, rather than aid, the intervention process.

Lack of progress/development. Anyone who is a parent knows how rewarding it is to watch his child grow and develop. The excitement experienced by parents who see their child stand alone for the first time and speak his first words is unparalleled by other experiences. This excitement is a natural reinforcement system which stimulates the parent to keep working with the child to achieve new skills (Heward, Dardig & Rossett, 1979). For many parents of emotionally disturbed children, there are very few rewards. Either the child does not progress at all, or the development is so slow that it takes an inordinate amount of effort, practice, and patience to achieve only partial progress. Is it any wonder that many parents feel frustrated and begin to question whether the level of progress is worth the effort? The real miracle is that so many parents are able to continue to work with such children, without knowing whether their efforts are effective. The rewards, if any, are few and far between, but many parents feel that when they do appear they are much sweeter and more cherished because they are so rare.

Public Opinion. The parents of disabled children "face the public" each and every time they leave their homes, and they must constantly battle the ignorance of the layman. Many people have incorrect assumptions about the cause of the condition and the extent of ability or disability of the child.

The parents are constantly faced with the decision of whether to try to educate the individuals or to just endure their inappropriate comments (Helsel, 1978). Many parents feel that it is necessary to appear well-adjusted and in control of the situation, regardless of how they actually feel (Bennett, 1978). They find themselves hesitant to go out unless they have the strength to handle the constant strain of confrontations, explanations, and maintenance of image. It is difficult to maintain this image, especially when they often receive cruel and abusive comments--comments that hurt even when the speaker is trying to be helpful. The parents easily become gun-shy and thus imagine a negative reaction from strangers when none is actually present. The axiom, "once burned, twice cautious," can be exemplified and multiplied by these parents.

Pressure from spouse or family members. The pressures that stem from opinions are not limited to those outside of the home. Parents are not a single unit. They are often considered to be a united front against the world, but this is often not the case. Many marriages are not able to withstand the added pressures that an emotionally disturbed child places upon them. Each parent has his or her own orientation and interpretation of the factors affecting the child. Overs and Healy (1973) stated the reason for this very well:

> Probably the single most important influence on a person's action or decision is the person's attitudes, beliefs, and values. As structuring and ordering devices, attitudes, beliefs, and

> values precede logical thinking and do not derive from logic or rationality. Therefore, the influence of basic attitudes, beliefs, and values on actions or decisions is primarily of an emotional, not an intellectual nature (p. 90).

If the parents are not able to reach a point of agreement on specific issues, then there is a constant added strain that affects the entire family.

Pressures come not only from the spouse, but from the siblings and members of the extended family, who also feel that they should have input into the events that affect the child, as they, themselves, are also affected by these events. They must be led to understand the important issues so that they can have enlightened interaction with the child and parents (Heward, Dardig, & Rossell, 1979). The pressures that these family members can place upon the parents are more severe than those of outsiders because of the increased emotional significance they play in the parents' decision-making processes.

Pressure from "support groups". A parent support group should be formed for the purpose of providing an information-source for parents, providing social interaction with others who can understand the stresses faced by the parents, for allowing the parents to see that they are not alone in their struggle, for providing a list of alternative methods of interaction with the child, and as a central location for child-advocacy activities. These issues will be discussed in a later section. There is one problem with parent support-groups, however, that has not been adequately recognized: they can increase, rather than decrease, the pressures that are on the parent. This happens when the parents are made to feel that they are not being good parents unless they are actively participating in such groups. Many groups pressure parents to "volunteer to work for their child" in activities that require a lot of time and energy which the parents might not have available (Bennett, 1978). The unspoken assumption is that if the parents do not run to fulfill the request then they don't really care for their child. It has been shown that many parents are already stressed to the limit of their capacities. The added pressure is very unwarranted and can lead to the withdrawal of parents from the group altogether. This can be avoided if it is remembered that the purpose of the group is to support the parent, not for the parent to support the group.

Loneliness. Many parents have expressed the fact that they have a feeling of loneliness (Sarason & Doris, 1979). This is more evident in the parents of adolescent emotionally disturbed children (Bennett, 1979). When a child is born, parents understand that there will be several years when their social life will depend upon the availability of babysitters, or upon those activities which can include the child. They expect to be able to stop having to arrange for child-care when the child reaches adolescence, and consequently they can more easily increase their social interactions outside the home. Parents of emotionally disturbed adolescents must continue to provide for child-care if they are able to get out of the house. Child-care for the emotionally disturbed child is difficult or impossible when the child is young, and it becomes increasingly difficult as the child gets older. Thus, the parents find themselves cut off from social interactions with other adults (Morton, 1978). These parents also have a multitude of problems and concerns that are different from those of parents of normal children. Things of seemingly serious concern to parents of normal children can be viewed as minor to parents who must deal with a very disruptive child. This can put the parents into different planes of reference and make interaction between them more difficult. It can, indeed, lead to the development of a feeling of being cut off and alone.

Parental death. Parents try to provide for their children in the event of their own deaths. This includes insurance, possibly a burial plan, and maybe a relative who agrees to take care of the children until they reach legal age. Parents do not expect to die before their children are self-supporting, and statistically, they are supported in these expectations. The parents of the severely disturbed child must face the knowledge that they will probably die before their child does, and that the child will probably never be able to be self-supporting (Sarason & Doris, 1979). Many of these children require an extensive amount of care for their entire lives. It is one thing to ask a person to take on the responsibility of a normal child for five to ten years; it is an entirely different matter to ask that person to take on the responsibility of a disturbed person for twenty to forty years! The situation is further complicated by the fact that it is difficult, if not impossible, to use the present legal system to try to insure that the child's care is consistent with the standards set by the parents. This issue forces the parents of disturbed children to recognize their own mortality far earlier than those parents of normal children (Sarason & Doris, 1979). The frustrations met in trying to make adequate provisions for the child are definitely added stressors.

Financial needs. Raising normal children is an expensive process. Add to this baseline the different special costs that are inherent in caring for an emotionally disturbed child, throw in the bureaucratic red tape that is normally required if financial assistance is to be obtained for the child, and don't forget to include the economic and political fluctuations that effect the availability of funds. This recipe makes a very volatile mixture, which can increase the stress-load of the parent just as gasoline can fuel a fire. With enough fuel, an explosion can result--or the fire uses up available resources and burns out.

Lack of relief. All of the stressors thus far have had one common theme: they are constant, day-after-day problems that are never solved (Morton, 1978). As was previously stated, these parents cannot stop being parents of an emotionally disturbed child. Adequate child-care is very rare and must be saved for necessary occasions, such as working hours. Many parents state that they feel they have lost their identities as persons (Bennett, 1978). They become Joe's mother or Sally's father. Their whole existence begins to revolve around the continuous battle with the stressors. They must be available to solve one crisis after another, with little reward, and no relief. They are not allowed to step out of the situation even long enough to regroup and rearm their defenses. Thus parents of adolescent, emotionally disturbed children often have a haggard-tired look that portrays their exhaustion (Morton, 1978). These parents need some time out. They need to have some time for themselves with which to find the person who is hidden behind the responsibilities. A few short weeks of total freedom from these responsibilities can make a major difference in the capabilities of the parent. Programs that work with these parents and children need to recognize this problem and make provisions accordingly. This issue will be discussed in more detail later in the paper.

Dealing with professionals. The final topic was reserved until last because it can be the most damaging of any of the stressors listed. The most often-voiced complaint from parents is the frustration they feel when trying to interact with those who will influence what intervention-methods are to be used with their child (Blatt, 1978; Helsel, 1978; Roos, 1978; Sarason & Doris, 1979; Schulz, 1978). Of course, not every professional is frustrating to the parent, but unfortunately, most parents state that these are the exceptions rather than the rule.

There are several areas in which this frustration can occur. First, the parent comes to the professional needing clear, concise information, presented in a manner that the parent can understand (Roos, 1978). Instead, they either do not get any information or the information that they do get is explained in highly technical terms. Either way, the parent is still in the dark about exactly what the problem is. Also, many professionals hesitate to say that they do not know everything about the problem. They feel that this will decrease the confidence of the parents. This is a mistake, as a wrong guess can have devastating consequences for both the parents and the child.

Once they have a baseline of information about their child's condition, the parents need a list of the available options for intervention-methods, with non-biased recommendations as to which option would be most appropriate. Too often, the parents are not given a choice by the professional. They are told, "This is what we are going to do," as though the parents had no choice (Roos, 1978). There are always choices, and it is up to the parents to make informed decisions about what happens to their child.

Third, the parent is the person who must live with the child on a day-to-day basis, and thus is the one most affected by, and influential in, the changes that occur in the child. Many professionals treat the child as though he were isolated from the parents; others act as though the parentswere totally responsible for the child's problems. Either orientation is wrong. Although some problems can be traced to the home-environment, others, such as autism, definitely are not. However, the child is in the home, and the intervention-methods used are definitely influenced by, and, in turn, influence the parent. If the particular treatment suggested cannot fit the particular situation, it will not be implemented properly. Lack of recognition of this fact can destroy the effectiveness of any treatment program.

Finally, and most important, the parent has a vast store of information that can be invaluable to the professional in assessing the child. This is true of the initial diagnosis, and of the continual progress of the child. Far too often, the parents are treated as though their input was worthless. Even those parents who are also professionals have stated that they have been treated as though they cannot be objective and report valid observations when discussing their own child. Colleagues who request the parent's professional expertise for another child will sometimes push aside the same information when it is applied to the child of the professional parent (Roos, 1978; Turnbull, A., 1978). What is this need of many professionals to totally disregard the information that parents have to offer? Is it conceit, superiority, or self-defense? The authors are not trying to insult any professional reader. Many times, the professionals do not realize the extent to which they are guilty of this behavior, and, to some degree, all of us are. If the professionals can put themselves into the parent's place, listen to themselves from the perspective of the parent, perhaps videotape some of their interviews and critically assess themselves, then they can discover how guilty or innocent they are of this crime, and try to adjust their behavior accordingly.

The role of the professional as a stressor is at once the easiest and the most difficult to alleviate. Individually, we *can* each work to view our interactions with parents from their perspective and try to meet their needs. This would drastically reduce the stresses felt by the parent. We *cannot* control the behavior of the other professionals with whom the parents must interact. Also, there are many bureaucratic rules and regulations of the institutions represented by the professionals which might cause frustration. We *can* let the parents know that we understand their feelings of frustration, and try to assist them in dealing with them. The next section of this article will discuss various methods of intervention with parents to help them reduce stress.

ASSESSING PARENT NEEDS

Combatting parent burnout is a necessary part of any intervention program for older emotionally disturbed children. Parents who have lived with these stresses for years often reach a point where they feel that they cannot go on. When the parent of an emotionally disturbed child says, "but I have my own life to lead," what he/she is often saying is that the stress of raising the child is becoming too much (Reid, 1971). This is a cry for help that must be addressed in order to maintain family stability.

The question is, how can we best deliver the needed services to the parents? Past attempts have assumed that all parents need all of the services that professionals have to offer (Alexander, Kroth, Simpson, & Poppelreiter, 1982). Slowly, professionals are coming to realize that the needs of parents vary at different stages in the child's educational life (Coletta, 1975) and thus no one approach can address all needs of all parents. Professionals have to analyze the needs and skills of the parents and attempt to individualize the services as much as possible.

This means that professionals must be flexible in the planning of an assistance program. It is true that the needs of the children are great, but the needs of the family are greater (Stewart, 1978) and can only be met by offering a variety of services that require different levels of commitment from the parents.

SERVICE OPTIONS

The most common service options offered to parents are individual and/or group counseling (Paul & Epanchin, 1982). There are some parents who need intensive individual counseling to help them deal with the problems of everyday life. There are other families that will greatly benefit from some form of group therapy. This can be especially true in parents of secondary-age emotionally disturbed children who have had to deal with the problems associated with raising such a child day in and day out, year after year.

Individual counseling and family therapy are excellent intervention methods, and should be offered to parents who need this type of help. The authors, however, believe that the needs of many parents can be met through other, less intensive means. This assumption is based on the belief that parents have different needs at different times in their child's life and, thus, their availability for involvement will vary from time to time. If only these two options are available, professionals are not adapting their services to the needs of the parents.

For example, one overwhelming need of some parents is respite from their emotionally disturbed child (Alexander, et al., 1982). This need is often viewed by the community, and by some professionals, as a rejection of the child. Respite is an effective means of lessening the constant stress of parenting such a child, and can be essential for the mental health of the family. A summer camp, special summer sessions, or a short-term institutionalization can allow parents time to rest, regroup, and strengthen strained family relationships.

Professionals should not only help arrange for some type of respite, but need to assist parents in dealing with any guilt that might arise from the decision. Very often, all that is required is for someone to say that he understands the parent's reasoning and agree that the time can be beneficial to both the parents and the child. This will help parents feel more secure in the decision and allow them to use the time for stress-reduction rather than increasing feelings of guilt and anguish.

Another critical need of parents is to be provided with accurate, understandable information concerning their child's condition and the intervention program being used. Conner, Riesalem, and Cruickshank (1971) asked parents of the handicapped what service they most needed from professionals. The overwhelming majority said that their greatest need was for someone to sit down with them and explain, in terms they could understand, their child's disability, what they could expect in the future, what was being done for their child, and how they could help. When people are informed, and have some idea of what to expect, stress is reduced and the ability to cope with the future is expanded.

The school would be the agency in the best position to carry out this service. They have access to complete information on the child: medical, psychological, and educational. Also, providing this type of service would help to raise the parent's respect for, and confidence in, the school. Many parents, especially those of adolescents, have a long history of negative contacts with the school, and therefore view the school as part of the problem rather than part of the solution (Alexander, et al., 1982). An excellent example of this is a statement made by the mother of a secondary age autistic child that a phone ringing during school hours sent a chill through her body, wondering what the child had done now (Jones, 1980). If parents could come to view the school as a source which they could turn to for information and support, they would feel less alone and more in control of their situation.

Another way of helping the parents deal with the stress associated with the rearing of an emotionally disturbed child is the parent support-group. This is not a group-counseling situation, but an association of parents who meet to discuss common concerns and exchange views on raising their children.

One great benefit of such an organization is that meeting with other parents who have similar problems helps to lessen the feeling that one is alone in facing such problems. Often, the simple knowledge that others share in this unusual life-situation relieves tension and makes the parent's existence a little easier.

A parent-group also gives the parents of older children a chance to give assistance to parents of the younger emotionally disturbed. They can give assistance in child-rearing techniques and give the parents of elementary-age children information on who to turn to for support in the secondary school, as well as what pitfalls to avoid. An extra bonus of this situation is that the parents of the older children usually find it refreshing and an ego-boost to help others, rather than receive help for a change.

A SAMPLE PROGRAM

The senior author has been working with a group of parents to establish such a support-group, and the services that the parents are interested in provide an excellent example of the types of activities parents need. The group is being formed by parents for parents, so the services being included represent what they feel is necessary, rather than what professionals feel is necessary.

One of the first things that the parents want is to develop contacts with those in the community who can help them become better parents. They are interested in receiving information from an attorney on will and estate planning for their child. They also want to find out about respite services, and how to qualify for financial services to help defray any costs such services might require.

Along the same lines as respite services is the desire to set up a baby-sitter service. The parents are very interested in finding people who are willing to sit with their children so that they can get some time together. One mother said that she felt she could deal with anything, if only she and her husband could go out to dinner or a movie once in a while. We often forget how difficult it is for these parents to get a sitter and how refreshing a night out can be.

Counseling services, both group and individual, were suggested, but it is interesting to note that this was one of the last items considered. Formal counseling can help, and for some it is a necessity, and the parents recognize this. They seem to feel, however, that counseling alone will be of little help to them.

By being flexible and allowing the parents to make the major decisions in the planning of the group, we hope to form an organization truly responsive to their needs. Care is being taken to prevent parents from feeling pressured to attend meetings or give more time to the organization than they feel comfortable with. The idea is to allow parents to decide on the level of involvement most beneficial to them and to allow them to change that level as their life-situation changes.

This last point--keeping the pressure off--is perhaps the most overlooked aspect of professional services. The goal of any assistance program should be stress-reduction, and this can only be accomplished by a concerted effort on the part of professionals not to add to the problem by making unreasonable demands on people who are already stretched to their limit of tolerance. When this is added to a program of flexible services, designed to meet individual needs, we will have done a great deal to alleviate parent burnout.

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Learned Helplessness: A Family Perspective

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ABSTRACT: Learned helplessness is a phenomenon wherein people are repeatedly exposed to situations beyond their control. Such exposure results in passivity, decreased interest and a reduction in the initiation of responses. These individuals have learned that their responses have no effect on outcomes. In this presentation the learned helplessness paradigm was employed to provide new insight into these problems as they are experienced by handicapped children and their parents. Treatment strategies presented emphasized 1) setting realistic and attainable goals, 2) developing a recognition of the control which does exist, and 3) promoting a better understanding of the causes for failure.

THE ROLE OF MENTAL HEALTH IN THE MINISTRY OF THE CHURCH

Theron M. Covin

"Stir up the gift of God which is within you...For God hath not given us the spirit of fear; but of power, and of love, and of a sound mind."

II Timothy 1: 6-7

The next time you are driving by a school and see children playing, count out at random any twenty five of them. Think about what the experts in the various fields of mental health have to tell us about the future emotional state of these children when they become adults. Assuming that these children are representative of a "normal population," we can predict that out of 25, 2 will be committed to a hospital for the insane at some point in time before his or her death, 4 will be profoundly neurotic, 4 will be moderately neurotic, 4 will be mildly neurotic, and the remaining 11 will be fairly normal. In other words, approximately 56 percent of the children will grow up to have poor to extremely poor mental health.

Why? They were not born having poor to extremely poor mental health. They did not inherit "bad" mental health. They grew up to have bad mental health because they learned characteristics of persons having bad mental health and chose to employ them in daily living and/or chose bad mental health as a form of adjustment. Bad mental health is a matter of choice except in situations where there are organic problems contributing to bad mental health. We know that even the person who is the most insane generally chose to be this way. Often insanity is chosen as a form of adjustment.

The state of the mental health in our nation today is one of overpowering darkness and despair. The cold statistical data represent an immense level of psychological pain among the people of our land. Yet in our land where resources are plentiful, one wonders why the continued suffering.

Perhaps it is time for us to look behind the grim statistics on mental health and look at the suffering human beings these data represent. We need to look at these people who have the same feelings as you and I have. Perhaps it is time to read and to respond to these data, with compassion and through Christian love. Each statistic represents a human life full of suffering and the tragic loss of human potential and happiness, a fullness of life, the loss of a God given gift.

For the sake of its spiritual integrity, the church of today, regardless of denomination, must take a sincere interest in the problems of poor mental health. We know enough about religion--we know enough religion to ten times over solve the mental health problems of the world today. The church cannot afford to be caught, perhaps as the medical profession is caught in the medical model which is based upon physical sickness for survival, in a model which focuses upon spiritual lack of well being for its survival.

We must do something to rid the church of the image the news media, writers, etc. have projected as having no measureable positive or negative effect on the mental health of our nation and as an institution, not having devoted much more attention to mental health than has society at large.

Someone, perhaps a more objective observer than you and I, developed a modern paraphrase of a familiar story to illustrate the apathy of the church toward mental health: A certain man went down the rocky, twisted road on his inner journey. The thieves of unhappy experiences, disappointments, and anxieties robbed him of his mental and spiritual well being, leaving him broken and bleeding beside the road of life. A minister came by, and later, a leading church layperson. Both saw the poor man broken in spirit beside the road. But they were very busy on their way to a meeting and other important matters--so they walked by on the other side. After awhile, a mental health professional came by that way. The mental health professional saw the man broken in spirit, and had compassion on him, binding up his wounds. Then the mental health professional took him to a halfway house where he could regain his mental health. Who, the was a neighbor to him that fell among the thieves of mental health? The church has nothing to gain, lots to lose, if it continues to plod along as in the past, in relation to important aspects of mental health.

Mental health is important in the ministry of the local church. The mental health delivery system is a part of the ministry of the church. The following model can easily be adapted by any church in its ministry:

1. Orientation. The church should deliberately provide adequate insight for all its members into the field of mental health. The fact that everyone has mental health, some good and some bad, should be realized. The topic of mental health should be one which can be discussed openly and without shame, fear, etc. A healthy orientation relating to mental health is an essential part of the ministry of the church.

2. Education. We know that good mental health is caused as well as bad mental health is caused. We also know that each person makes a choice as to the type of mental health he or she has. Since the ministry of the church is to enhance the mental health of its people, a deliberate effort must be made to provide the proper mental health education and to provide proper decision making skills to its members.

3. Consultation. Consultation should be available to church members for mental health related issues such as when one has questions about ways to gain better mental health or when one has a minor problem which can be solved with the proper information.

4. Crisis counseling. Support, comfort, and encouragement are often needed by church members. The church should provide such for its needy members as well as the opportunity to explore various alternatives to problem solving.

5. Referral. When the problem is beyond the scope of the services and resources of the church, proper referral to the most qualified mental health professional should be available. The individual needing help should be guided to the proper resources to ensure proper treatment of the presenting problem.

The role of mental health in the ministry of the church seems to be a most important one. The church, an agent of God, is commissioned to stir up the gift of God, a part of which is a sound mind, which is in each man, woman, boy, and girl. Therefore, mental health is a central and inescapable concern of any church ordained by God. It is an essential part of the healing, redemptive fellowship of the church.

Today, the church is in a strategic position to have a great impact on the mental health movement in the United States. The model presented in this paper, if deliberately carried out, can ensure a positive delivery of mental health services to the members of the churches who decide to use such an approach.

SECTION II: BEHAVIORAL CHANGE

OVERVIEW: The first paper in this section is that of Dr. Paul A. Alberto, another of the featured speakers of the conference. Dr. Alberto discusses the use of mild aversive stimuli for control of stereotypic and self-injurious behaviors. Dr. Walt Antonow and Deborah T. Orr describe techniques for decreasing aggression and self-harm, and Dr. Barbara Marotz gives techniques for improving the social acceptability of emotionally disturbed children.

Descriptions of two research studies are given. Lonny W. Morrow, John G. Burke and Billie J. Buell co-author a report on the effects of a self-recording procedure on attending-to-task behavior and academic productivity. The relative cost effectiveness in behavior reduction programs of reinforcement and punishment is reported by Deborah T. Orr, Dr. Walt Antonow, and Dr. F. J. Eicke. Finally, a report on the use of restraint as a positive reinforcer is made by Mary Anna Springfield.

The reader is also referred to "Putting It All Together: Programs for Autistic and Emotionally Disturbed Students in the Memphis City Schools," in Section IV. A portion of this presentation is devoted to descriptions of behavior management techniques used in a residential program for the autistic.

THE USE OF "MILD" AVERSIVE STIMULI FOR CONTROL OF STEREOTYPIC AND SELF-INJURIOUS BEHAVIORS

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One of the immediate priorities for teachers of severely emotionally disturbed children must be to gain control over self-injurious and stereotypic behaviors. These behaviors are of immediate concern because of the potential harm that they will cause the student, and because of the obstruction they present to instruction. Self-injurious behavior refers to behavior patterns that produce physical injury to the individual's own body (Bachman, 1972). These behaviors range from relatively mild self-slapping to such severe head banging and body biting that if the individual were permitted to engage in the behavior for any appreciable period of time the resultant tissue damage would be extensive and possibly life-threatening. Stereotypic behaviors are repetitious, topographically invariant motor acts, or sequences, for which reinforcing or controlling stimuli are unknown, and which are in a functional sense maladaptive (Baumeister & Forehand, 1973). Stereotypic behaviors interfere with attention and learning (Koegel & Covert, 1972), interfere with previously learned behaviors (Lovaas, Litrownk, & Maun, 1974), and interfere with observational learning (Varni, Lovaas, Koegel, & Everett, 1979).

In response to what were growing concerns in the area of treatment ethics, behavioral guidelines were adopted by the National Association for Retarded Citizens which emphasized the use of procedures regarded as least restrictive, i.e., differential reinforcement, extinction, exclusion time-out, response-cost and overcorrection. It was recommended that the use of any punishment procedure to reduce self-injurious behavior should be preceded by attempts to establish alternative behavior patterns through environmental stimulation and reinforcement (May, Risley, Twardosz, Friedman, Bijou, Wexler, et. al., 1975).

The literature suggests however that the use of such nonaversives has had limited effectiveness (Baumeister & Rollings, 1976). Altman and Haavik (1978) state that differential reinforcement response suppression occurs gradually over an extended time period; consequently a great deal of self-injury may occur in the process. Differential reinforcement being an insufficient procedure independent of a concurrent aversive procedure has been written about by Altman & Haavik (1978), Corte, Wolf, & Locke (1971), Dorsey, Iwata, Ong & McSween (1980), Risley (1968); this being especially the case with high frequency behaviors (Gaylord-Ross, Weeks, Lipner, and Gaylord-Ross, 1983). In reviewing techniques for reduction of such behaviors the most consistently found success has not been with reinforcement based procedures, but with procedures which exercise more aversive control (Baumeister & Rollings, 1976; Russo, Carr & Lovaas, 1980).

Smolev (1971) writes: "...while nonaversive procedures may be preferable to aversive control because they involve less discomfort for the subject such procedures may allow subjects to injure themselves, a behavior that might be quickly suppressed with punishment. Therefore, when danger to the subject, or staff limintations, preclude the use of extinction, differential reinforcement, punishment is indicated." Dorsey, Iwata, Ong, and McSween (1980) write: "...although the continued refinement of reinforcement based procedures remains critical, additional research on the use of more restrictive techniques is also warranted. Punishment has been found to be the most consistent of all behavioral treatments in reducing self-injurious behavior. ...and in cases where DRO, extinction, etc. are either ineffective or exceedingly slow acting punishment may represent one of the few alternatives."

There are two broad categories of aversive procedures for the reduction of inappropriate behaviors (Alberto & Troutman, 1982). First is procedures which use conditioned aversives. These are procedures which result in psychological or social discomfort to the subject. These include use of consequences such as verbal reprimands, warnings, and activities. Second is procedures which use unconditioned aversives. These are procedures which result in physical pain or discomfort to the subject. These include use of consequences such as trauma and shock. It is evident that use of conditioned aversives has had little initial impact upon reduction of the behaviors in question. The use of unconditioned aversives is of highly questicnable professional and ethical concern in the publicschool classroom; and result in an array of undesirable side effects. With these considerations in mind one can identify a growing body of literature which presents a set of procedures which may be labeled as "mild" aversives. In comparison with conditioned and unconditioned aversives, mild aversives may be seen as resulting in annoyance or irritation to the subject. This set of mild aversive procedures has the effect of significant behavior reduction, and should not present similar ethical concerns when employed appropriately. Mild aversives may include the use of a form of nonseclusionary time-out known as facial screening, the administration of certain substances, to include water, citric acid, and aromatic ammonia; and the use of negative practice.

Facial Screening

Facial screening (a.k.a. visual screening) is a form of nonseclusionary time-out by which at the onset of an instance of inappropriate behavior the practitioner covers the subject's face blocking out all visual stimuli. This procedure has been conducted with the use of a terry-cloth bib or use of the practitioner's hand. Zegiob, Jenkins, Becker, and Bristow (1976) employed facial screening with a young schizophrenic child who engaged in stereotypic hand-clapping behavior. The procedure involved the use of a terry-cloth bib which was pulled loosely over the child's face for ten seconds concurrent with the presentation of a verbal reprimand. If the behavior continued, the bib remained over the child's face until he stopped clapping for three seconds. This procedure was conducted during language training sessions in which the student was being asked to imitate sounds and words. At the end of the procedure the child had gone from a mean of 8.17 minutes of hand clapping to a mean of 0.6, and from a baseline mean of 7.5 correct verbal responses to a mean of 27.3 correct verbal responses. At two and six month post checks, following the fading out of the facial screening, hand-clapping was at zero levels. Zegiob, Alford, and House (1978) used a terry cloth bib, this time with a profoundly retarded boy and instances of self-striking. Through use of this same procedure the suppressive effects generalized to non-consequated acts such as striking objects, self-biting, body rocking, and flapping.

Lutzker (1978) also used facial screening by placing a terry cloth bib over the face and head of a twenty-year-old male contingent upon the occurrence of head and face slapping with hands and fists. The placement of the bib was concurrent with a verbal reprimand. The bib was held over the subject's face until he had stopped the behavior for three seconds. Lutzker employed a multiple baseline across three classrooms. In Classroom A there was a baseline mean of 70 occurrences of self-injurious behavior in a thirty minute session. Following treatment this was reduced to a mean of five occurrences of self-injurious behavior. In Classroom B there was a baseline mean of 61 occurrences; following treatment this was reduced to a mean of five occurrences. In Classroom C there was a baseline mean of 53 occurrences; following treatment this was reduced to a mean of two occurrences.

Singh (1980) employed facial screening using a terry cloth bib with an eleven-month-old severely retarded, cerebral palsied infant. The infant had been thumb biting to the point where there was severe flesh damage. Sessions were multiple baseline across two time periods, one prior to the afternoon nap and one prior to being put down for the night. Each time the infant bit himself he was verbally reprimanded, his thumb was taken out of his mouth, the bib was quickly placed over his face and head and held loosely at the back of his head for approximately three seconds. Intervention lasted for 23 sessions. Follow-up was conducted once per month for twelve months and the behavior remained at zero levels.

McGonigle, Duncan, Cardisco, and Barrett (1982) employed visual screening with the experimenter covering the subject's eyes with his hand contingent upon the occurrence of the inappropriate behavior. This study was done with four children, two nine-year-old moderately retarded children who engaged in stereotypic waving of objects and vocalizations; and two 13-year-old profoundly retarded children who engaged in self-injurious behaviors. Treatment was conducted both in the classroom and in their group home. The therapist placed one hand over the child's eyes while holding the back of the child's head with the other hand. Duration of the visual screening treatment was a minimum of five seconds for each child. Criterion for release from visual screening was contingent upon nondisruptive behavior following expiration of the minimum time requirement. Following treatment all children were brought to zero rates. The moderately retarded children remained at zero rates at 12 and 18 month follow-ups, and the profoundly retarded children remained at zero rates at six month follow-ups.

Use of Substances

Water misting: Dorsey, Iwata, Ong, and McSween (1980) employed the use of a water mist as a mild aversive consequence for the self-injurious and stereotypic behaviors of seven subjects. The six females and one male ranged in age from five to 26-years-old. Their inappropriate behaviors ranged from the mouthing of objects (for some of whom this resulted in vomiting or hand biting), to head banging and tearing of flesh from the lips and forearms. The procedure involved the application of a fine mist of water directed toward the subject's face contingent upon the occurrence of the targeted behavior. Tap **Water** was sprayed using a standard plastic plant sprayer. Within four sessions of the introduction of the water misting, self-injurious behaviors decreased to below 5% of the baseline intervals. When compared to baseline, behaviors were suppressed an average of 51.5% during initial treatment phase and 60.1% in the second treatment phase. All subjects at the completion of the intervention were brought to zero rates of occurrence. In discussing their treatment the authors noted certain cautions in the use of a water mist procedure: 1) water remaining on the face and clothing might occasion or exacerbate colds or other illnesses, 2) no sessions were or should be conducted when symptoms of a cold or fever are existing, 3) at initial sessions considerable amounts of water were used and therefore a thorough towel drying of the child may be necessary, 4) it is possible that prolonged facial exposure to water might produce chapped skin requiring the application of a surface treatment (e.g., petroleum jelly) either before or after sessions or at various times throughout the day.

Citric acid: Citric acid (lemon juice) has been used for reduction of a diverse group of behaviors. Sajwaj, Libet and Agras (1974) used lemon juice for the control of life-threatening rumination in an infant. Five to ten ml. of Real Lemon lemon juice was squirted into the infant's mouth whenever rumination or its precursors were detected (i.e., tongue thrusting). For the next 30 to 60 seconds no lemon juice was administered. The procedure lasted for eight weeks. In baseline the infant ruminated during 40 - 70% of the intervals. Following treatment this was reduced to 10% and then near zero rates. Twelve month follow-up indicated no further instances of rumination.

Cook, Altman, Shaw, and Blaylock (1978) employed the contingent use of lemon juice to eliminate public masturbation by a severely retarded seven-year-old boy. The lemon juice was contingently administered during six random periods of time during the day. Upon initiation of the target behavior the teacher or aide and subsequently the mother would squirt five to ten ccs. of lemon juice into the boy's mouth with a plastic squirt bottle. After sixteen treatments with the citric acid (13 days) the subject was down to zero rates of occurrence. The intervention was terminated when zero rates were maintained for 11 consecutive days. A follow-up was conducted for one week following six months and the behavior was seen to remain at zero rates.

Mayhew and Harris (1979) employed citric acid to decrease the self-injurious behavior of a 19-year-old profoundly retarded young man. The subject was engaging in fist and hand striking of his head, head to door and hard objects behavior, and screaming. These authors used a solution of one ounce of food grade citric acid to one quart of water, a solution similar in taste to commercially available concentrated unsweetened lemon juice. Never more than two ounces per day were administered. During treatment sessions when the targeted behavior occurred the experimenter first shouted "no." If the subject ceased immediately for 15 seconds nothing else was done. If the behavior was emitted again within 15 seconds the experimenter shouted "no" and squirted the lemon juice into the subject's mouth. During baseline the subject engaged in 11 occurrences of the self-injurious behavior per minute and screamed for 96% of the intervals. When the citric acid was administered these behaviors were reduced such that self-injurious behavior was occurring .46 times per minute, and there were no intervals of screaming. When a reinforcer was then paired with the administration of the citric acid for appropriate head orientation to the trainer, the self-injurious behavior was reduced to zero levels and the screaming was maintained at zero levels.

Aromatic ammonia: Tanner and Zeiler (1975) used the contingent use of aromatic ammonia with a 20-year-old autistic woman who engaged in self-slapping accompanied by vocalizations and screams. The experimenter used crushable capsules of the Burrough's Wellcome Company. A capsule of ammonia was crushed and thrust under the subject's nose when she slapped herself, and was withdrawn when she stopped. The ammonia was used whenever the young woman brushed her hair back from her forehead since it was observed that the slapping behavior was always preceded by this movement (although the movement was not always followed by slapping). During baseline the subject engaged in a mean of 36.2 slaps per minute. During the initial treatment phase this behavior was reduced to a mean of 0.7. In a second treatment phase capsules were administered by all staff who came in contact with the subject and behavior was reduced to zero occurrences. A twenty-one day follow-up indicated zero rates being maintained.

Baumeister and Baumeister (1978) used aromatic ammonia with two severely retarded children to suppress mouthing of fingers which was causing lesions, face and leg slapping and hair pulling. All staff who came into contact with the children were involved from the beginning of this study. Because of the high frequency of the behavior of the four-year-old he was placed on a variable schedule of punishment. The contingency was in effect for a two minute period about once every fifteen minutes. As the response rate decelerated the relative frequency of the punishment was increased, the objective being to reach the point at which each response was punished. Ammonia was held under the nose until the first clear indication from the child's behavior (struggling, coughing, crying) that fumes had been inhaled. For the seven-year-old the same procedure was in place, but her rates were lower so she was on a CRF schedule for the punishment. The four-year-old had a mean baseline of 52.4 instances per minute. By the fourth day of treatment this was completely suppressed, and was so for two months. A follow-up four months later indicated only three occurrences of the behavior. For the seven-year-old baseline slapping was 11.3 per minute, hairpulling 5.6 per minute. By the fifth day of treatment the behaviors were completely supressed, and at follow-up there were no reoccurences.

Altman and Haavik (1978) employed this same intervention with a four-year-old severely retarded, cerebral palsied child who engaged in hair pulling behavior. The intervention demonstrated the effectiveness of contingent use of ammonia in deceleration of the hair pulling and it was generalized with family members and school personnel supressing the behavior in the home, the grandparents' home, and in the school.

Singh (1979) demonstrated the effectiveness of ammonia capsules with a 15-month-old who held his breath. Whenever the infant held his breath the experimenter thrust a vial of aromatic ammonia and held it four inches away from the nose and issued the verbal reprimand "no, don't do that." After each episode there was three minutes of ignoring. If after three minutes there was no breath holding, the infant was cuddled. During baseline the infant engaged in a mean of 1.2 episodes of breath holding per day, a mean of 76.7 seconds. Following the first five days of treatment there were only five episodes, of five to ten seconds in length. In the second five days there were no episodes of breath holding.

In discussing the use of this procedure the various authors noted certain cautions: 1) check with a physician for medical contradictions that might be associated with ammonia inhalation, 2) immoderate use, or undiluted forms would be destructive to the nasal mucosa. However, though the fumes are very unpleasant they appear to produce no lasting effect when used moderately and in diluted form, 3) if the subject begins to mouth breath cover the mouth.

Negative Practice

Negative practice is a reduction procedure wherein the student is required to engage in exaggerated experience with the inappropriate behavior. The goal of negative practice is for behavior reduction through response fatigue. Alberto, Powell, Troutman and Sharpton (1982) used a negative practice procedure with an 11-year-old female diagnosed as severely retarded and severely disturbed. The youngster engaged in hand flapping behavior. She was seated directly in front of the teacher during motor imitation instruction sessions. Each time she began hand flapping, instruction was stopped. The teacher delivered a sharp verbal reprimand, took the subject's hands and guided flapping them for 30 seconds. The teacher then sharply said "no more," waited five seconds and began the next imitation trial. During baseline the subject engaged in a mean of 123 flaps per ten minute session. Following intervention the behavior was brought to near zero rates; and appropriate responding to imitation instruction was brought to criterion. Six month follow-up data indicated the maintenance of hand flapping behavior at near zero rates.

Discussion

To date the data indicate that the use of mild aversives presents the teacher with an effective means of behavior reduction without the ethical and professional disadvantages associated with the use of unconditioned aversive stimuli, nor the disadvantage of delayed effect associated with the use of differential reinforcement strategies. In addition to the effectiveness of these procedures the various authors have noted several other advantages: 1) they are easily administered during instructional sessions, 2) they are portable across settings, 3) it is easy to train various school/institutional personnel and family members, 4) they can be administered immediately following the inappropriate response, 5) they have no lingering effects, 6) no harm comes to the student if carefully administered, and 7) they are low in cost.

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Decreasing Aggression and Self-Harm: Prevention and Intervention Techniques Useful With the Severely Emotionally Disturbed Client

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Session Format

Two hour, 30 minutes presentation and demonstration of techniques for decreasing aggression and self-harm. Audiovisual aids will accompany the first part of the presentation.

Summary

Decreasing Aggression and Self-Harm (DASH) is a comprehensive system, applicable with the severely emotionally disturbed client. The content of the workshop will deal with structuring of the environment, to prevent crisis situations. Techniques which are practical in dealing with crisis situations, such as client physical aggression and self-injurious behavior, will also be presented to the audience. Based on the size of the audience group and their prior familiarity with intervention techniques, active audience participation may be expected.

Purpose of Objectives of Presentation

Upon completion of the workshop, the participants will be able to select and implement appropriate client management systems to prevent the client from displaying aggression and self-harm. The participants will become familiar with various intervention systems, in use across the nation, for dealing with the aggressive client. The participants will become familiar with specific techniques for effective elimination of self-injurious behavior. Finally, the participants will be able to make sound judgements in selecting the most appropriate prevention and intervention systems for their specific client population.

Target Audience

Psychology, education, and direct-care personnel working in a community or residential setting. Parents of severely emotionally disturbed individuals will find the workshop useful as services consumers.

Description of Presentation

Several professional training programs, for training service providers to deal with physical aggression, have been developed since the seventies. The first effort, to the authors' knowledge, involved direct training of staff trainers in residential facilities. The training, lasting for two consecutive weeks, was provided by an organization called "The Camelot Behavioral Systems," from Kansas. The training, which was considered excellent by its participants, relied on demonstration and practice. At one facility, the North Mississippi Retardation Center in Oxford, Mississippi, ten staff members received training. Of the ten trained in 1973, three remain in the employ of the Center, with only one feeling confident enough to continue providing the training for new staff members, using materials developed by another group as a mnemonic aid.

An offshoot of the Camelot Behavioral Systems, developed by a former instructor of Camelot and his associates, is a system of self-defense procedures known as C.O.P.E. which is an acronym for "Controlling Outbursts and Preventive

Exercise." The authors of this system, John J. Bell, Bruce Ligget, and Mary Coleman, published a manual in 1975 to aid the training of participants in remembering the techniques demonstrated during the workshop.

Bell et al. included a section on prevention of physical aggression which, although brief, provided some ideas for cognitive consideration. The manual lacks clarity of techniques, according to its initial readers as well as those who have participated in workshops conducted by Bell of his trainees.

In the summer of 1976, Barbara Fisher, Phil Leveck and Susan Sloan from the Aurora Center in Illinois held a workshop demonstrating the use of defensive measures useful with physically aggressive, mentally retarded individuals. One of the attendants of the workshop, Bob Broadfoot, an employee of the Green Valley Developmental Center in Tennessee published an illustrated manual demonstrating the techniques he learned at the aforementioned workshop by Fisher et al. Broadfoot has provided training for state funded facilities within the state of Tennessee and has distributed his manual. Some criticism of several techniques presented by Broadfoot has swayed three of the four state facilities away from the Broadfoot system, which is called S.P.I.T. (Simple Preventive Intervention Techniques), with the subsequent adoption of other methods listed within this narrative.

Broadfoot has also published an excellent, practical, guide to the prevention of situations which lead to physical aggression. The manual, called "Wait a Minute," provides everyday hints for dialogue with frustrated or angry individuals, suggestions for injecting humor to refocus attention, and hints of the effects of voice quality and tone.

The latest available printed material on managing physical aggression manifested by mentally retarded and emotionally disturbed individuals has been published in 1980 by Luke S. Watson, James Owen, and Randy Uzzell. The manual, entitled "A Positive Approach to Managing Disruptive Behavior," contains a chapter on the prevention of disruptive behavior through standard behavior modification techniques (positive reinforcement) and suggestions for avoiding frustrating situations by choosing ability appropriate tasks for the client. The manual is photo illustrated and is distributed at workshops, dealing with the same topic, conducted by Watson. The workshops are conducted in the large metropolitan areas on a regular basis. The focus of Watson's workshops are on the structuring of the client's day, with a minimum of the one day workshop devoted to intervention with the physically aggressive client.

Richard M. Foxx made a considerable contribution to staff training through his nationwide workshops and, most recently, through a videotape series designed for the teacher, teacher aide, and direct care worker within a residential setting. The workshops and the videotapes deal with all of the behavioral techniques, from positive reinforcement to punishment, which are applicable to the mentally retarded population. The videotape series presents several hands-on techniques useful for controlling and subduing physically aggressive clients and students. The presentation of the techniques dealing with physical aggression is brief and not all inclusive, since the intent of the series was to provide a wide spectrum of behavioral methods -- with the primary focus being skills acquisition training.

Why Another System?

The system of prevention and intervention within this proposal is not "another panacea." The proposed system relies on the selection of the most effective methods, as determined through field tests at two state residential facilities (North Mississippi Retardation Center, Oxford, Mississippi and Nat

T. Winston Developmental Center, Bolivar Tennessee), four Activity Centers (Work Opportunity Resource Center, Tupelo, Mississippi; Itawamba Adult Training Center, Fulton, Mississippi; Lafayette County Adult Activity Center, Oxford Mississippi; and Hardeman County Activity Center, Bolivar, Tennessee), and four Group Homes (three in Mississippi and one in Tennessee).

The following outline will be followed in the workshop, and indicates its content.

PREVENTION TECHNIQUES

1. Pre-enrollment Planning -- getting to know the client's habits, behaviors, likes, and dislikes. Knowing the potential stimuli which may trigger physical aggression.
2. The First Day -- informing the client of the rules and regulations of the training setting. Spelling out the consequences of unacceptable behaviors alleviates misunderstanding, frustration, and possible "crisis" situations.
3. Consistency of Staff Behavior -- inconsistency of responses and actions account for the greatest number of acts of physical aggression.
4. Overcoming Fear -- through confidence in self and the techniques of prevention and self-defense.
5. Structuring the Environment -- (a) providing for a safe environment for clients and staff; (b) providing for an environment that involves the client in interesting and productive activities throughout the day.
6. Attention -- the most valuable reinforcer for most people, which can shape inappropriate, as well as appropriate, behavior.
7. Common Sense -- self-protection through common sense prevention techniques, such as: denial of self-exposure to attack; attention to behavioral cues; and resistance to making false promises or threats.
8. Dealing with Psychotic Episodes -- cues to "unpredictable" behavior; discriminating between psychotic and attention seeking "bizarre" behaviors; medical intervention.

INTERVENTION TECHNIQUES

The Intervention Techniques to be demonstrated in this workshop include the following:

1. Demonstration of blocks for basic punches: concentration will be on preventing injury to staff and client.
2. Demonstration of blocks for various kicks delivered by the client. Takedown techniques, which prevent injury to client will be also demonstrated.
3. Demonstration of avoidance of bites and prevention of serious injury from bites. Techniques of getting out of a bite, once prevention failed, will be demonstrated.
4. Demonstration of release from arm grabs, to include release and restraint procedures.
5. Demonstration of release from hairpulls.
6. Demonstration of escapes from chokes attempted by clients.
7. Demonstration of escapes from complex holds, such as headlocks, bearhugs, etc.
8. Demonstration of takedown techniques which minimize injury to staff and clients.
9. Demonstration of hands-on restraint techniques, to include chair restraints, desk restraints, and full body restraints.
10. Demonstration of transport techniques, from one location to another, of physically aggressive clients.

Follow Up Activity

A question and answer period will follow the demonstration.

Improving the Social Acceptability of Emotionally Disturbed Children

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Not only do emotionally disturbed (E.D.) children tend to function poorly in academic areas, but they tend to experience difficulty in social interaction as well. One of the defining characteristics of emotionally disturbed children as indicated in P.L. 94-142 is "an inability to build or maintain satisfactory interpersonal relationships with peers and teachers" (section 121a.5; originally from Bower, 1960). Yet the individual educational plans written for these students tend to emphasize academic areas and independent work habits, and perhaps the reduction of some extremely inappropriate behaviors. Seldom do educators seem to build into the E.D. students' programs a plan for increasing appropriate social interaction.

There are powerful reasons for giving attention to the social ability and social acceptance of E.D. (or any) children. These include the following:

1. Increased social skill development tends to result in more frequent and longer lasting social interaction. This increased social interaction is, in turn, conducive to further social skill development (Mueller & Brenner, 1977). The amount of social interaction is considered the most significant variable affecting friendship formation and maintenance (Hallinan, 1976).

2. Increased ability to interact socially with others appears to aid cognitive development as well as social and personal development (Lewis & Rosenblum, 1975; Strain, Cooke, & Apolloni, 1976).

3. Mastery of social skills is considered by some personality theorists as essential (though perhaps not sufficient) for a healthy self-concept

(Elardo & Elardo, 1976). If we can interact appropriately with others, we are likely to receive greater amounts of positive reinforcement from them (Gottman, Gonzo, & Rasmussen, 1975), which may help us in giving more positive reinforcement to ourselves.

4. Peer popularity (as determined by sociometric testing) has been found to relate to several indices of mental health, including reduced incidence of psychiatric referral, delinquency, and suicide (Gottman et al., 1975).

5. Our success and reported happiness in our everyday environment seems to depend as much or more on our ability to get along with others as on talent, above-average intelligence, or non-social achievement (O'Malley, 1977).

With the definite need for improving social skills and acceptability of E.D. students and the strong evidence supporting the significance of this area, one might question why it is still so infrequently given sufficient attention. There are probably a number of factors underlying this neglect, including inadequate and unsystematic methodology for measuring and evaluating social ability, a lack of the detailed, systematic hierarchy of appropriate skills characterizing many academic areas (see Stephens, 1978, for a refreshing attempt to develop this detail), and the degree to which the social domain is affected by values issues, As teachers of these students, we cannot afford to wait until the field is systematized before we begin our intervention efforts.

Assessment

As with academic areas, assessment of social skill and acceptability must precede intervention. The assessment process in behavioral areas typically begins with teacher referral, often utilizing a teacher rating. As there is presently no rating scale of which this presenter is aware that deals specifically with social skill and acceptability, it may be sufficient for the teacher simply to identify students s/he views as lacking or inappropriate in social skill or acceptability. A two-pronged identification would be preferable, whereby students lacking skills are distinguished from those who have the social skills but appear unmotivated to use them, perhaps due to greater immediate "payoffs" for inappropriate social behavior.

The most frequently used method of assessing social acceptability is a sociometric rating, which could serve as a second indicator in our assessment. Here, students select the peers (usually three to five) with whom they most like to interact (eg. to play with at recess, or to eat lunch with). They may also be asked to identify the three to five peers with whom they would not like to interact. Since research has indicated that on the less desirable end of the selection continuum are ignored rather than actively rejected students (Gottlieb, Semmel, & Veldman, 1978), both positive and negative sociometric choices are needed to identify both types of students. Sociometric data also reveal the highly selected student who may be useful as a peer helper in later intervention strategires.

Probably key to the assessment process is direct observation of a student's interaction with peers. This may be broad based or highly specific. Broad based observation may simply keep track of the percentage of time a student spends in appropirate and inappropriate interaction, and alone. Each of these categories would have to be clearly defined, if reliable data are to be collected. For example, behaviors recorded as "alone" may include not only totally isolated behaviors but also watching of peers from the sidelines without interaction, and parallel play. A little more controversial is the classification of talking with adults; some students seem to use this activity as a means of avoiding peer interaction.

Examples of behaviors coded as positive interaction include the obvious ones of conversing or laughing with peers, but also participation in an organized game, even during moments when no immediate interaction is occurring.

Examples of behaviors that are likely to be recorded as negative interaction include hitting, kicking, name calling, insulting, and verbally rejecting. Perhaps most difficult to code is roughhousing behaviors, where children are "playfully" pushing and shoving. In this case, other non-verbal cues like smiles or frowns and the degree of force involved may be helpful in determining whether positive or negative interaction is occurring.

Again, with this three category coding system, children who are withdrawn and children who interact inappropriately can be distinguished. Withdrawn children should spend a large percentage of time alone, while children who interact inappropriately should have a larger than usual percentage of negative interaction recorded.

Specific observations can be made of behaviors assumed important for adequate social interaction. It should be noted that our research supported knowledge base in this area is still in the "intelligent guess" or "professional hunch" category. Few behaviors have been empirically demonstrated to be vital for appropriate social interaction (Van Hassette, Hersen, Whitehall, & Bellack, 1979).

Behaviors involved in initiating interactions are frequently selected for obse vation (and later intervention). These may include greeting another, beginning a conversation, asking to join or be joined in a play activity, and asking a question of another.

Once an interaction has begun, there are a number of behaviors conducive to maintaining that interaction. Possible targets of observation are conversing, sharing, taking turns, cooperating at an activity, smiling and laughing, and play skills. Listening and emphathic responding could also be observed. Language and motor pre-requisites are common to social skillfulness.

Socially skillful children also need ways to resolve conflict: means for minimizing physically aggressive behaviors of others and ways to respond to verbally abusive or rejecting comments. Responses to these negative behaviors from peers could be subject to specific observation.

A thorough assessment also may need to examine others in the student's environment. Sometimes increasing the student's social acceptability dosen't mean just changing him or her but also modifying the ability of others to accept differences in children.

In school settings, a high amount of social conformity seems the rule; perhaps the limits of what is acceptable can be extended, whereby both peers and teachers can be more socially supportive than they presently are to children with special needs.

Intervention

Let's say your assessment is complete; you know what your goals are in terms of social skills and acceptability for a given E.D. student. Now what? In this section, intervention strategies falling into three categories will be discussed: those aimed at changes in the classmates of the E.D. student, changes in teaching strategies and those focusing on the E.D. student him/herself. The supposition behind this division is that attention should be given to changing teacher and peers of an emotionally disturbed child as well as that child.

Unfortunately, there are no easy or pat answers for what to do with a socially unacceptable child. But we are beginning to gather some data on strategies that have made a difference with some students in some settings. All strategies presented here have been researched and found to be successful in at least one study, as presented in the social interaction literature that is developing.

For regular classmates. Strategies aiming at changing classmates focus primarily on regular classroom peers, as the regular classroom is still the preferred setting, given that the E.D. student can be successful there. All four strategies included in this area involve students supporting rather than competing with one another.

Group meetings can be held on a regularly scheduled basis or following a social problem situation. Through discussion and role playing methods, students can be taught a greater awareness of others' feelings, what fairness is, what it means to be in a relationship, and similar social cognition goals. After altercations, student awareness may be increased as to how it takes two to have a fight, and how hostile or self-defensive statements can escalate a situation.

A *buddy system* seems to work most effectively with withdrawn students. In this strategy, a popular, cooperative student is asked to include the problem child in play situations for a limited period of time. Caution should be taken that the "buddy" is willing to participate (although the way a teacher asks for this assistance can make this more likely; be positive and enthusiastic). Several students may take turns being buddies, perhaps for a week each. Everyone can win: withdrawn student gains a helper, and the "buddy" learns a lesson in social responsibility.

A similar strategy involves grouping students for projects and in class activities to support the sociometric choices of the special needs child. A caution: don't group E.D. students with someone they have chosen who has indicated s/he didn't want to play with our handicapped students.

Finally, get kids playing compliment games. The goal is for students to learn to support one another (and the classroom climate) by giving legitimate compliments to each other. At first, compliments tend to be based on physical characteristics primarily (eg. "I like your blue shirt.") but with time and modeling, students can become quite aware of each others' strengths.

For teacher. Teachers can make some alterations in their usual teaching and reinforcement practices which can have a positive effect on individuals within their classrooms, and help to build a positive classroom atmosphere. One tactic is to use descriptive praise; especially for cooperative and appropriate social behavior, but also for behaviors in general. Descriptive praise tells a student exactly what s/he is doing that is working; for example, "you took turns beautifully today." This type of praise avoids two potential hazards of other praise statements: it avoids the comparisons that can lead to competition or giving up (eg. only one student can be the recipient of "you are the best behaved student in this class") and it assures that the student knows what s/he is doing well. General statements like "nice playing," although helpful to building a more positive conception of oneself, may be too vague to cue the student to develop specific social or behavioral attributes.

Using group rewards is another strategy where everyone can be a winner, and contribute to oneself while also contributing to the entire class. Group reinforcement has been shown to foster a cooperative spirit within the classroom. For example, class members as individuals can earn points or tokens for a group party, or subgroups can earn rewards for meeting a subgroup goal. It is important, if a group goal is to be used, that all members of the class are capable of meeting that goal, with support.

Teachers can encourage peer tutoring, in conjunction with group rewards or separately. When students support one another in this manner, they are learning that knowledge and competency have their responsibilities as well as their rewards. Successful tutoring can result in a payoff in self-esteem for both tutor and tutee; the tutor knows s/he is contributing to another (especially if we use descriptive praise to tell him/her), while the tutee is gaining new skills or knowledge.

It is also important for the teacher to model his or her acceptance of the E.D. student. This may be difficult at times, since certain behaviors of this child may be highly unacceptable. Yet they aren't (even though it may seem that way) performing these undesirable behaviors all the time; it is vital that we seek out and find positive attributes in each student. Especially in early elementary years, students tend to adopt the attitude of their teacher, so it is up to us to model the values we'd like them to develop.

For the E.D. student: Our emotionally disturbed child typically needs to develop some new behaviors and ways of relating if s/he is going to function successfully in life. Some ways of developing these may need to occur outside the classroom, but with plans for generalization and reinforcement back to the regular setting.

Specific skills training may be needed. Typically, a small group setting with two to six children, is appropriate for this. Skills of initiating and maintaining social contact may be taught, as well as methods for solving conflict situations. Teaching includes a minimum of direct instruction; modeling and a chance for behavioral rehearsal predominate. Multiple chances to actually practice a particular skill may be provided, such that overlearning results. Practice should be extended and reinforced, through "homework," into the natural environment (eg. recess).

The hero procedure is a twist on a reinforcement program whereby the student earns rewards or privileges for himself or herself and others too, and thus gets to be a "hero" or special person to other members of the class. The "others" involved in the reinforcement can be just one other person (eg. the child earns a trip out to dinner for herself and a close friend), a small group (eg. the student earns a party, which includes some subtle social skills training, for a small group of peers), or the entire class (eg. the student earns minutes towards an extra recess for the entire class). Caution generally must be taken that the procedure has a positive emphasis such that peers will support the child rather than castigating him or her for failure. One way to do this is to make failure impossible; reaching the goal just will take longer if the student doesn't extend himself.

The *barb technique* is useful with a student who is frequently teased or verbally rejected by peers, and has an overreaction to such harrassment that results in greater difficulties for all involved parties. This strategy attempts desensitizatio of the student by intentional, scheduled teasing or rejecting comments in a controlled, safe setting. The student is previously told what to expect and has discussed appropriate responses to such teasing. Once the teasing has begun, the child is reinforced for responding in new, appropriate ways. The distinction between fact and opinion can be made where appropriate; many teasing comments are the opinion of the teaser, which doesn't make them the "truth."

Feedback to a student on their social performance in the actual play setting is probably essential. Consider beginning with comments only on what they did well. Later, rapport typically becomes stronger and the child grows in the ability to handle mixed feedback (ie. what they have done that *hasn't* as well as *has* worked in the social setting).

The student can be *trained* to be skilled in a desired play activity. This strategy involves determining an activity that is popular and has status among a particular group with whom the student is in regular contact, and then providing instruction and practice in that activity. Skill at sports activities especially seems to increase social acceptability.

Counseling can be provided, dealing with self-concept and personal areas as well as the interpersonal. This can be done individually or in a group, as needed. Ultimately, group counseling seems especially appropriate for social concerns; social skills training is actually one form of group counseling.

Allowing the student to play or otherwise interact with younger students is a final strategy to consider. Children with limited social skills frequently spontaneously seek out younger playmates; now it appears that there may be a useful reason to allow and even encourage this occurrence. It appears that younger children may be at a more compatible social level to our special needs child; this social similarity may promote social development.

Changing the social ability or acceptability of an E.D. student is not an easy task. The intent of this presentation was not to make social development seem like a simple goal, but to stress that it may be a vitally important goal and that a teacher may be able to significantly affect such development through the utilization of a variety of strategies.

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Effects of a Self-Recording Procedure on the Attending to Task Behavior and Academic Productivity of Institutionalized, Severe Behavior Disordered Adolescents

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The ability to attend to task is widely recognized as important to both increase academic productivity and prevent the occurrence of inappropriate behavior. Yet, many behavior disordered children and youth appear to be deficient in this behavior. To date, however, there has been apparently an absence of applied treatment research. The present investigations analyze the effects of a self-recording procedure on attending to task. Results strongly suggest that this procedure may be appropriate to increase both attending to task behavior and academic productivity of institutionalized severe behavior disordered adolescents.

Appreciation is extended to Larry Goldsmith and Jim Selinger for their administrative support for this research. Also, Kendra Moore and Calvin Yates are acknowledged for their assistance as observers.

INTRODUCTION

It is generally accepted that attending to task is a prerequisite to successful academic performance. Yet, inadequate attending skills are frequently listed as characterizing many children and youth with behavior disorders (Cullinan & Epstein, 1982; Quay, 1979; Telford & Sawrey, 1981). Lack of attending skills may not only result in a depressed rate of productivity but may also result in inappropriate classroom behavior which may have an adverse impact upon the student and his/her peers in classroom performance.

Fagen and Long (1976) advocated that the teaching of self-control skills is an essential component in treatment procedures for students with behavioral deficits and/or excesses. Hobbs (1966) indicated that a behaviorally disordered student "....... has fewer degrees of freedom in behavior than the normal child, yet he is not without the ability to shape his own behavior by self-administered verbal instruction. He can signal to himself if he can learn what the useful signals are". Strategies which can both teach students self-control skills and facilitate age-appropriate socially acceptable behavior in academic settings would be a welcome addition to teachers' skills repertoires.

Recently the use of self-recording procedures has been demonstrated to result in beneficial gains in level of attending to task (Broden, Hall, & Mitts, 1971; Glynn & Thomas, 1974; Glynn, Thomas, & Shee, 1973; Hallahan, Lloyd, Kasiewicz, Kauffman, & Graves, 1979; Hallahan, Marshall, & Lloyd, 1981; Thomas, 1976; Young, Birnbrauer, & Sanson-Fisher, 1977). Self-recording requires the student to determine whether he has emitted a particular behavior and then record the occurrence or non-occurrence of that behavior. Nelson (1977) found that students often change their behavior when they start to self-record regardless of whether they had been emitting a particular behavior.

Most of the research to date on the effects of self-recording has been done with students identified as learning disabled. No research was found which implemented a self-recording procedure with students identified as severe behaviorally disordered to ascertain its effects upon rate of attending to task behaviors or academic productivity. Also, no research was found which utilized this procedure with institutionalized, secondary youth.

The present investigations were designed to determine if institutionalized, severe behavior disordered adolescents would significantly increase the amount of time they spent on-task and academic productivity when utilizing a self-recording procedure. In both investigations a withdrawal design was implemented to demonstrate experimental control. The same procedures were followed in both experiments.

EXPERIMENT 1

METHOD

Subject and Setting

Jim, a 15 year old boy, served as the subject. He was carrying a diagnosis (DSM-III) of Schizophrenia, Undifferentiated Type. He had recently moved to the midwest from the East Coast and school records were non-existent. Available psychiatric records indicated that he had been hospitalized on three previous occasions for in-patient psychiatric treatment and suggested that he had infrequently attended school for several years. Although his measured intellectual ability indicated that he was moderately mentally retarded, the professional staff believed that he possessed at least low-average intelligence. There was a history of psychiatric disorders in the family. Academically, he was functioning in the mid-first to mid-second grade level.

Jim attended classes in a self-contained room for behavior disordered adolescents with three other students in a school located on the grounds of a state institution for the mentally ill. Observations and experimental programming were conducted daily during his mathematics period. The classroom was staffed by a teacher and two aides.

Recording Procedures

Observations were conducted daily during the investigation. A five-second time-sampling procedure was utilized to assess attending to task. If Jim was observed to be attending to task at the end of the five-second interval, the interval was scored as "attending". Attending to task was defined as "looking at his worksheet, sitting in his seat, writing on his worksheet, and remaining quiet". All other behaviors were scored as non-attending. Interobserver reliability was obtained on a minimum of 25% of all conditions. It ranged from 85% to 96% with a mean of 92%.

The observer also recorded the number of auditory cues from the audio-cassette tape Jim received during the treatment conditions.

This provided a method of comparison with the number of occasions Jim self-recorded.

Academic productivity was assessed by collecting Jim's paper at the end of each observation session. These were scored by an aide and interobserver reliability computed on 33%. Both the number of problems attempted and solved correctly were recorded. Interobserver reliability was 100% for both the number of problems attempted and solved correctly.

Design

A withdrawal design was implemented to assess the self-recording procedure. Baseline was followed by the Treatment Phase, a return to Baseline conditions, and a return to the Treatment Phase.

Baseline

During this phase, as with all phases of the investigation, Jim was asked to sit in his seat and complete a packet of mathematics worksheets. At the end of 20 minutes the packet was picked up and later scored.

Treatment

During the treatment phase, a cassette recorder with a specially prepared tape was placed on a bookshelf in close proximity to Jim's desk. A 5" x 8" grid card was taped on his desk. He was told that periodically he would hear a beep from the recorder. When he heard a beep he was to stop and mark a "+" on the grid card if he thought he was working on his worksheets or a "-" if he thought he was not working on the worksheets. The procedure was modeled by the teacher until Jim could correctly carry it out. At the end of 20 minutes the packet was picked up and later scored.

Withdrawal

During the withdrawal phase, Jim was told that it was no longer necessary for him to use the cassette recorder. Conditions were the same as the Baseline Phase.

Treatment

Jim was told that the use of the tape recorder was going to be reinstated. All other conditions were the same as Baseline Phase.

RESULTS

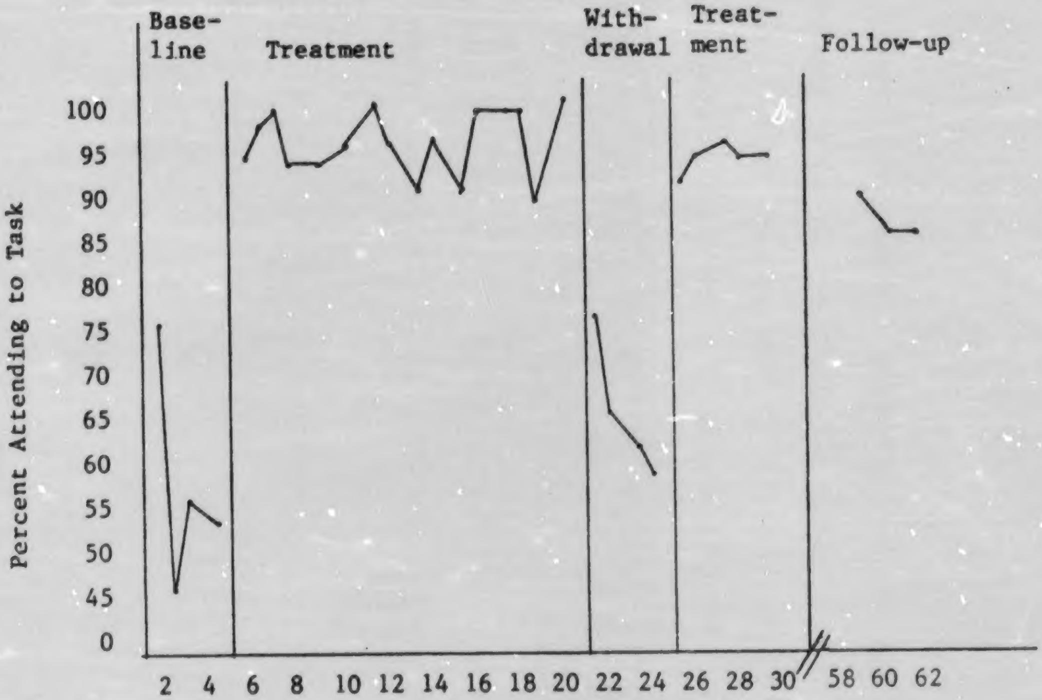
Attending to Task

The results of the self-recording procedure on attending to task are depicted in Figure 1. It is evident that the treatment procedure resulted in a quick and marked increase in Jim's attending to task behavior. The mean percent of attending to task during Baseline was 57%. When Treatment was initiated, it increased to a mean of 95%.

Insert Figure 1 about here

A return to baseline conditions during the Withdrawal phase resulted in a swift decrease in attending behaviors. Attending to task decreased from the Treatment mean of 95% to a mean of 63%. Reinstatement of the Treatment procedure resulted in another rapid and significant increase to a mean of 93% attending to task.

Probes taken on three consecutive days, 30 days after completion of the investigation indicated maintenance of treatment effects. The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Percent Attending to Task
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Figure 1

mean rate of attending to task was 87%.

Insert Figure 2 about here

Academic Productivity

As indicated in Figure 2, the mean number of mathematic problems computed correctly during Baseline phase was 14. Jim's performance increased to a mean of 120 problems computed correctly during the first Treatment phase. His performance decreased to a mean of 45 during the Withdrawal phase and again increased to a mean of 112 when Treatment was reinstated.

EXPERIMENT 2

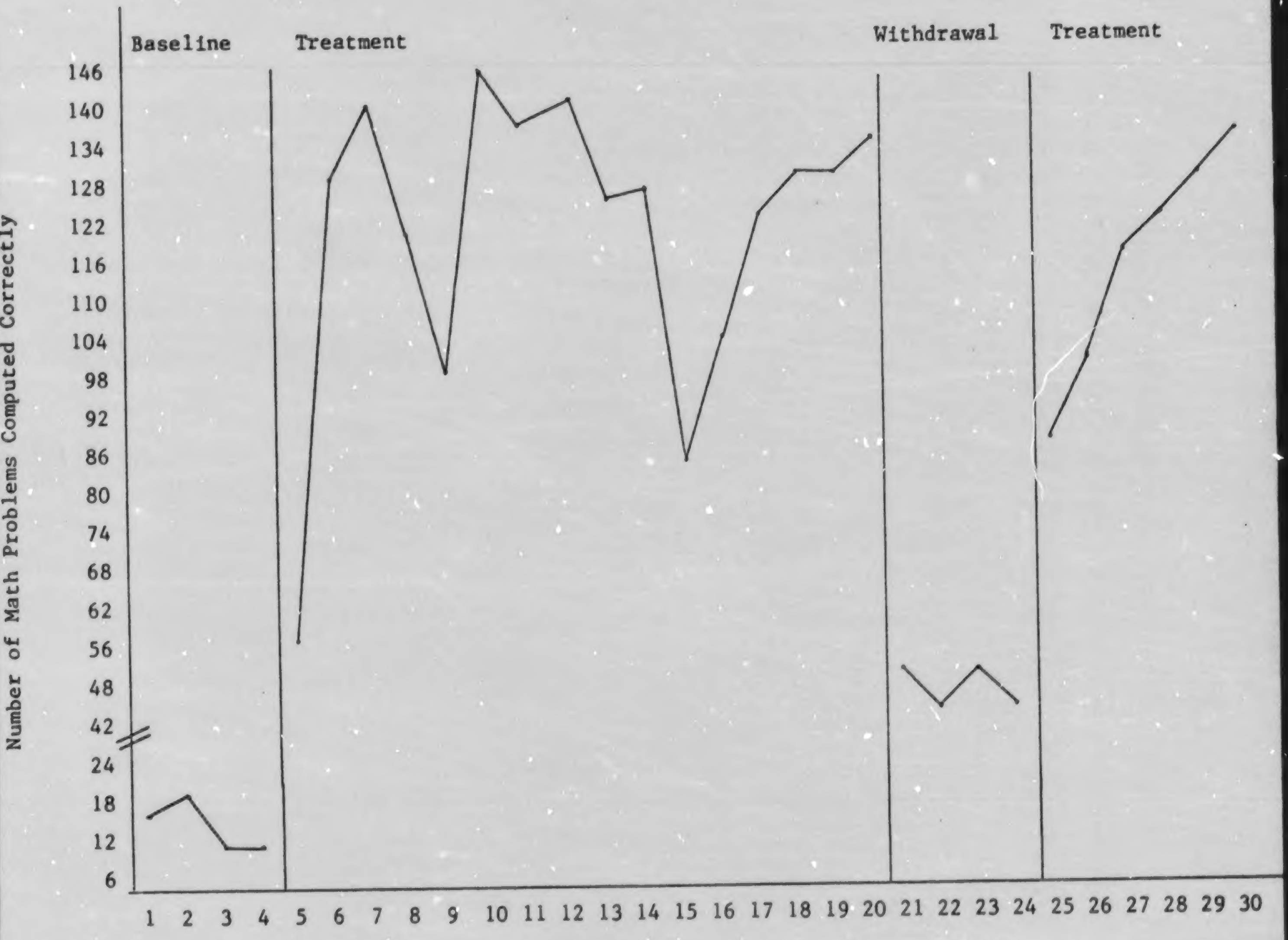
The second experiment was conducted to replicate the findings of Experiment 1 on a more severely and chronically disturbed adolescent whose behavior was more disruptive to the classroom environment.

Subject and Setting

Harold was a 17 year old who had a history of disordered behavior dating back to second grade. He had been institutionalized for 3 years in a state institution for the mentally ill. He was carrying a diagnosis of Schizophrenia, Undifferentiated (DSM III) Type. He was so disturbed and his behavior so bizarre that standard assessments could not be conducted. All observations were conducted in the classroom while he worked on computing basic mathematic problems.

Recording Procedure

A five-second time-sampling procedure was utilized to assess


Baseline
Treatment
Withdrawal
Treatment
Number of Math Problems Computed Correctly
146
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56
48
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28
29
30

Figure 2

Harold's attending to task. Interobserver reliability was computed for 25% of the observational periods. It ranged from 88% to 96% with a mean of 92% agreement. The number of problems attempted and computed correctly was recorded and 33% selected for interobserver reliability checks. Interobserver reliability was 100% for both number attempted and computed correctly.

RESULTS

Attending to Task

During Baseline, Harold attended to task a mean of 51% of the time as depicted in Figure 3. Much variability, however, was evidenced. When Treatment was implemented, his attending to task increased swiftly and significantly to a mean of 95% with little variability present. During the Withdrawal phase, his attending to task behavior decreased to a mean of 55%. It increased dramatically again to a mean of 94% when Treatment was reinstated.

Insert Figure 3 about here

Academic Productivity

The number of mathematics problems computed correctly increased from a mean of 22 during Baseline to a mean of 57 during Treatment. During the Withdrawal phase, there was a decrease to a mean of 25 problems computed correctly. That increased to 55 when Treatment was again implemented. Much variability in number of problems computed correctly was evidenced throughout all phases.

Insert Figure 4 about here

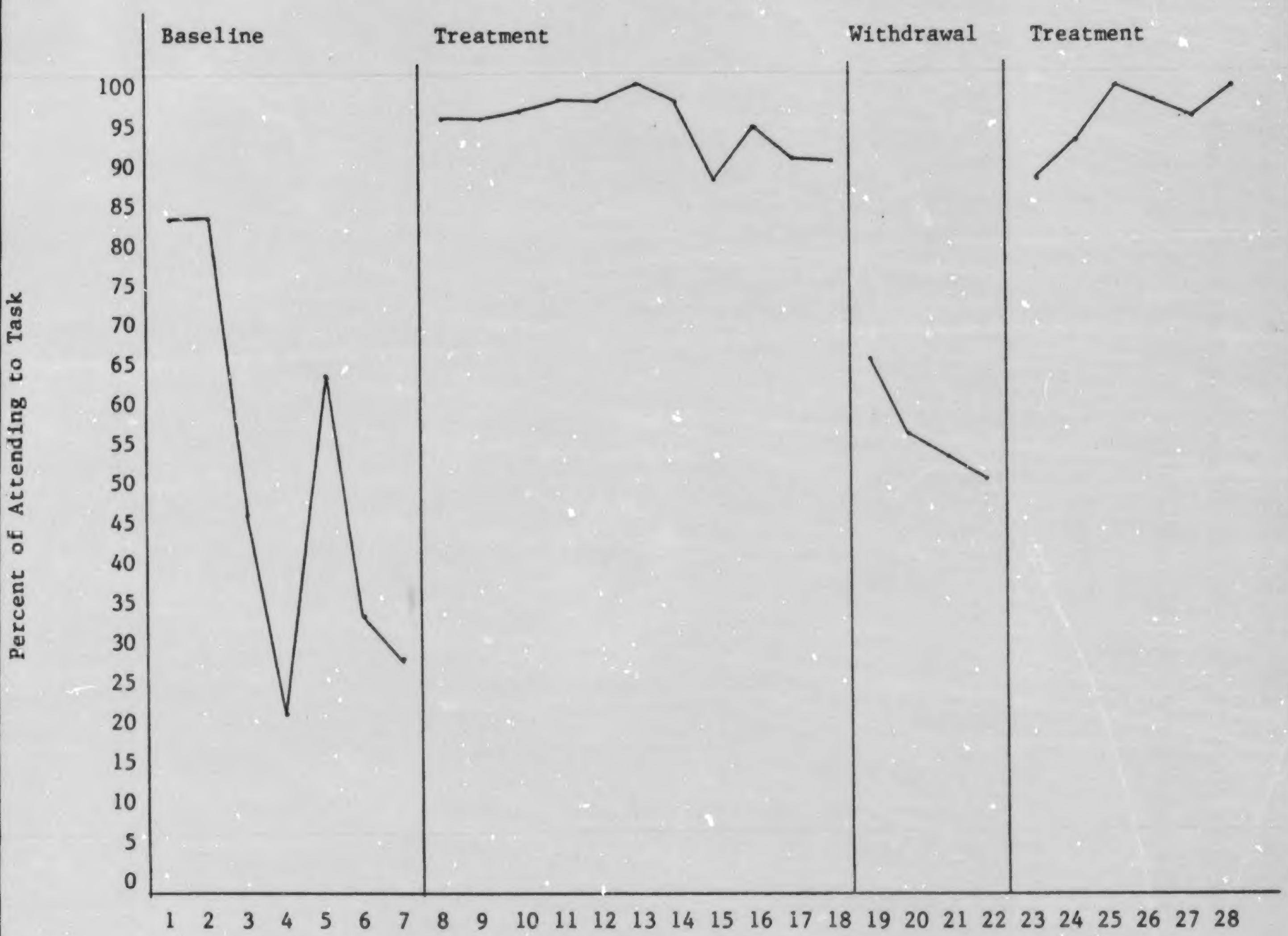
Baseline
Treatment
Withdrawal
Treatment
Percent of Attending to Task
100
95
90
85
80
75
70
65
60
55
50
45
40
35
30
25
20
15
10
5
0
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Figure 3

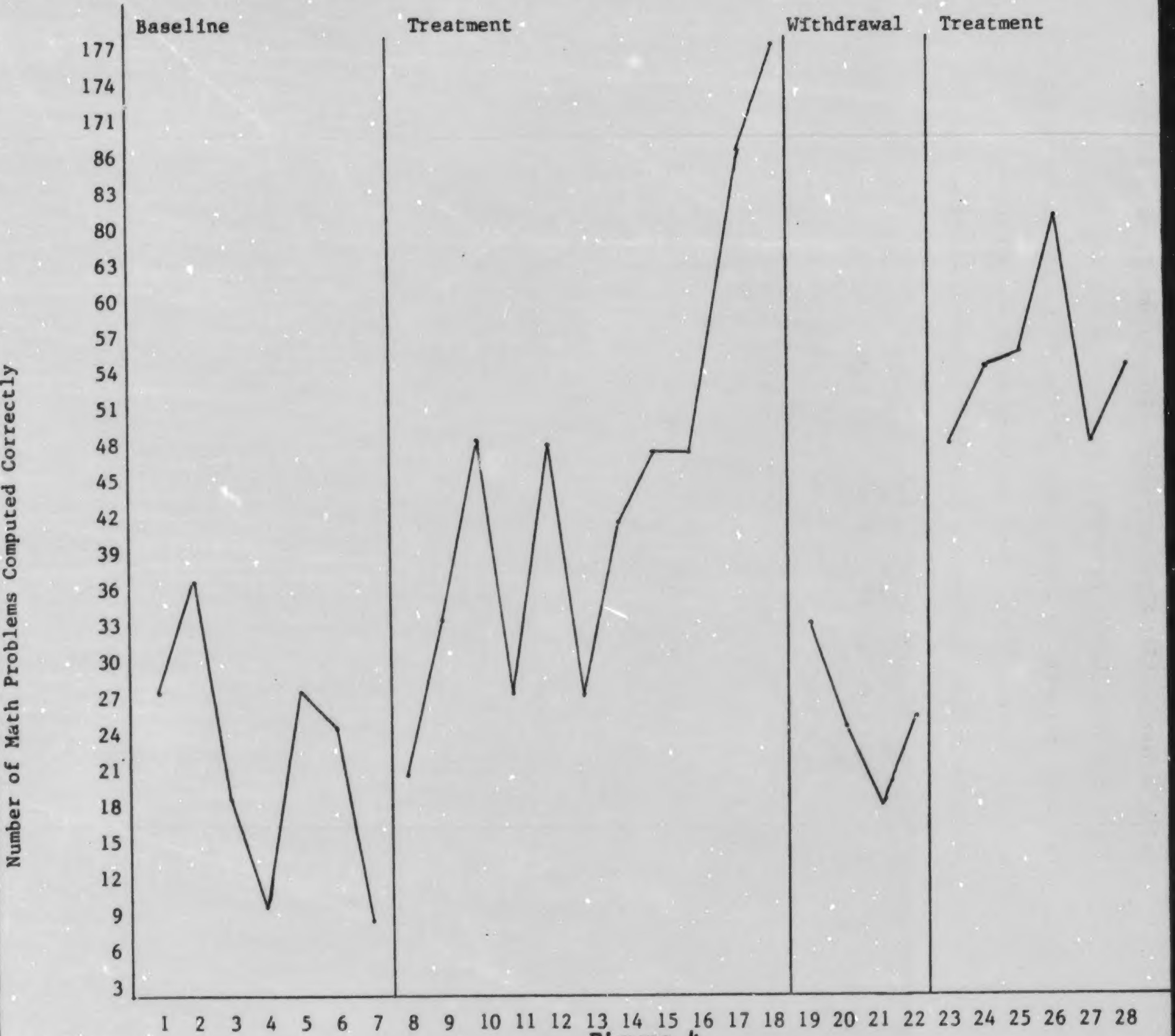
Baseline
Treatment
Withdrawal
Treatment
Number of Math Problems Computed Correctly
177
174
171
86
83
80
63
60
57
54
51
48
45
42
39
36
33
30
27
24
21
18
15
12
9
6
3
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28

Figure 4

SUMMARY

The results of these two experiments replicate those obtained by other researchers working with different populations (Broden, Hall, & Mitts, 1971; Glynn & Thomas, 1974; Glynn, Thomas, & Shee, 1973; Hallahan, Lloyd, Kasiewicz, Kauffman, & Graves, 1979; Hallahan, Marshall, & Lloyd, 1981; Thomas, 1976; Young, Birnbrauer, & Sanson-Fisher, 1977). They do, however, go beyond those and strongly suggest that the use of self-recording procedures may result in beneficial effects in increasing the amount of time institutionalized, severe behavior disordered adolescents spend attending to task. The technique may also be useful in preventing the occurrence of behaviors likely to disrupt the classroom environment.

While a relatively consistent pattern of academic productivity was obtained from Jim, much variation was evident in Harold's performance throughout all phases of the experiment. A significant improvement did, however, result whenever treatment was initiated. Thus, there did not appear to be a consistently high correlation between attending to task behavior and academic productivity. Additional research is required to better understand this relationship.

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Reinforcement and Punishment: Relative Cost Effectiveness in Behavior Reduction Programs

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Session Format

One hour research presentation and discussion.

Summary

Presentation of research conducted comparing the effectiveness of punishment with reinforcement, the staff time utilized for each technique, and the generalization of treatment in one setting to another setting. Presentation will include a description of the experimental method and research design, with in-depth discussion of results and implications of the study.

Purpose of Objectives of Presentation

The objectives of the presentation are to familiarize the participants with research conducted on common behavioral techniques. In-depth discussion will be provided to train the participants in implementing the techniques, with the mentally retarded and/or emotionally disturbed, in most applied settings.

Target Audience

All staff; non professional, para-professional, and professional who work directly with clients.

Description of Presentation

Research participants were nineteen males and females ranging from age twenty-two to sixty-two. They were diagnosed as falling within the profound to mild range of intellectual and adaptive functioning. All participants had a secondary diagnosis of emotional disturbance or extreme maladaptive behaviors as defined by the AAMD Adaptive Behavior Scale, Part II.

Four groups of approximately eight participants were randomly assigned to two reinforcement groups and two "punishment" groups to determine the relative success of these techniques in decreasing maladaptive behaviors. Staff were cued by a tape recorder to reinforce the participants assigned to the reinforcement group, using the differential reinforcement of incompatible behavior paradigm (DRI). Behaviors incompatible with the target behaviors were defined as "on task", "in seat," and "in transit." Reinforcement was set on a fixed interval schedule starting at one minute and increasing by one minute every day. Nonexclusionary time out was implemented with the remaining two groups by pulling the participant's chair away from the activity any time a target behavior was displayed. The participant remained in nonexclusionary time out until the target behavior had not been displayed for thirty seconds. Each group served as its own control.

An ABAB design was used beginning with a one week baseline period of recording. Two weeks of treatment followed the baseline period. A two week return to baseline was then introduced, followed by a three week reinstitution of treatment. In addition, staff time utilized for each of the procedures was collected at set intervals throughout the treatment phase.

The results indicated a significant decrease in maladaptive behaviors for the group undergoing the differential reinforcement of incompatible behaviors treatment.

Conversely, the groups receiving nonexclusionary time out evidenced a marked increase in maladaptive behaviors. Staff time data indicated that reinforcement procedures utilized less staff time than nonexclusionary time out.

Follow Up Activity

An abstract of the research will be provided in addition to graphs of the data obtained during the study. A question and answer discussion will be held to provide answers to any questions the participants have about applying the techniques research to individual settings.

Restraint as a Positive Reinforcer--
A One Year Follow Up

Mary Anna Springfield
Oakhaven Center for Autistic Adolescents

This presentation documented the methodology used to lessen aggressive, noncompliant, withdrawal behaviors of two students at the Oakhaven Center. A slide presentation pictorially showed sequential places involved in modifying these inappropriate behaviors by using restraint as a positive reinforcement. Other intervention had had minimal effect on these behaviors. Restraint as a positive reinforcer is an effective tool for use by direct-care personnel responsible for serving behavior disordered individuals.

SECTION III: CURRICULUM AND ASSESSMENT

OVERVIEW: The first paper in this section, by Dr. Anne M. Donnellan, provides educational implications for curriculum development and personnel training for provision of appropriate services to the autistic. Dr. Donnellan, one of the featured speakers of the conference, also made a small group presentation on specific curriculum issues in regard to this population. This presentation was not available for inclusion in the _Proceedings_. Dr. Judith K. Grosenick, the keynote speaker for the conference, also made a small group presentation, on discriminatory exclusion of disturbed students; this, too, was unavailable for inclusion.

Dr. Stephen B. McCarney describes the Behavior Evaluation Scale (BES), an instrument designed to aid in diagnosis, placement and programming for children and adolescents with behavior disorders. Clinical and educational perspectives on language intervention with autistic children are explored by Dr. Alan G. Kamhi, Lauren K. Nelson, and Lacy H. Wray. The selection of appropriate non-verbal systems for use with the autistic or severely emotionally disturbed was the topic of a small group presentation by Dr. Paul A. Alberto, another of the featured speakers of the conference; unfortunately, his presentation was unavailable for inclusion.

Dr. Andrea C. Sizemore discusses vision screening for the severely emotionally disturbed, and skill assessment for vocational training of the emotionally disturbed mentally retarded is described by S. K. Setbacken. Expanding leisure and recreational options for autistic adolescents through the use of creative drama is explained by Dr. Cynthia L. Warger. Dr. Dana P. Fredrick describes adaptations of a model program approach to practical teacher application. The final paper in this section, "What We Wish They Knew," by David F. Freschi, has important implications for all teachers and trainers of the severely emotionally disturbed and autistic.

AN EDUCATIONAL PERSPECTIVE OF AUTISM: IMPLICATIONS FOR CURRICULUM DEVELOPMENT AND PERSONNEL DEVELOPMENT*

Anne M. Donnellan
University of Wisconsin-Madison

Until the passage of PL 94-142, very few students with autism were afforded an education. Most were excluded from public schools and were able to receive an education only if they happened to live near one of a handful of private programs or could prevail on public school officials to "fudge" on the diagnosis and accept them under another label (Donnellan-Walsh, 1976). Teacher training institutions did not usually address the educational implications of autism, as their future teachers would be unlikely to encounter youngsters with autism in their classrooms.

Since the enactment of federal and state mandates, the situation has changed. These same youngsters are entitled to a free, appropriate education, at public expense, in the environment least restrictive of their personal liberties. That which had been a "charity" is now a civil right under PL 93-312 (Section 504) and the Fourteenth Amendment (Martin, 1979). With several years' experience, it seems appropriate to ask some questions about the implementation of the legislation, its impact on the students, and the adjustments the educational community has made in terms of program development, service delivery, and personnel preparation to meet the needs of this particular group of learners. A good first step is to look at the quality of educational programs now being offered these students and to judge whether they are, in fact, appropriate and provided in the least restrictive manner.

Observations of classrooms in dozens of states and provinces, interactions with hundreds of teachers and administrators, and consultation with many colleagues leads to the unfortunate conclusion that educators and parents ought to have serious concerns about how these students are being taught, what they are being taught, and where, with whom, and when they are receiving instruction. Concerned parents and professionals should also ask the important question, "What can we do about it?"

QUESTIONS RELATED TO INDIVIDUAL EDUCATIONAL PROGRAMS

How Are These Students Being Taught?

The questions related to technology are perhaps the easiest to address, although the answers are often disappointing. Fortunately, technologies for facilitating the educational progress of these students do exist (e.g., Lovaas, 1977; Koegel, Russo, & Rincover, 1977), and many are being used in school programs.

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Despite the overwhelming evidence that a highly structured, data-based empirical approach is necessary, far too many school programs are still weak, poorly articulated, and based on nebulous notions of psychoeducational, developmental, or analytic therapy. Less often now, we are hearing comments such as, "We consider autism a mental illness, so in our program the classroom is 'time-out' from school" (from a public school administrator in Missouri in 1977). However, we continue to hear such comments as, "I try not to impose myself on the child; I let her choose the activities she prefers" (from a public school teacher in Wisconsin in 1980), or "He knows how to behave, and so we have decided not to work with him until he decides to stop self-stimulating" (from a public school administrator in Alaska in 1979).

Even in classrooms which use behavioral approaches, the methods of educating students with autism too often attempt to replicate the laboratory settings in which the technology was developed. There is over-dependence on one-to-one instructional arrangements in small clinic-like cubicles.

Finally, both structured (behavioral) and unstructured (psychoanalytical) programs are often based on an inadequate knowledge of interventions necessary to deal with many of the severe behavior problems sometimes presented. Procedures used to manage inappropriate behaviors are too often negative (e.g., the use of time-out boxes), used without seeming awareness of the legal or ethical issues involved (Martin, 1979; Donnellan-Walsh, 1976), and implemented without a careful consideration of non-punitive alternative strategies (LaVigna & Donnellan-Walsh, 1976).

What Are These Students Being Taught?

Instructional activities in many classes for students with autism are irrelevant, artificial, age-inappropriate, non-functional, and based on curricula which may or may not be suited to the developmental needs of normal pre-schoolers. The following example (from the author's experience) is all too typical:

> Recently a seven year old boy with the problem of autism was observed during his fifteen-minute "cognitive" and "language" sessions in a one-to-one arrangement. The child is quite well behaved but essentially mute and displays few functional skills. The cognitive development activities included touching the biggest of three purple bugs on a ditto sheet and sorting yellow felt squares from red felt apples. During the language session he was asked to label or to imitate the label of various objects (including a yellow plastic bunny, a toy airplane, a plastic fork, a bottle of glue and a toy radio) and pictures including a camera, rock, fish, cloud, coyote, wolf, a man sweeping,

a boy kicking, a girl cutting, a girl opening and a boy feeding. When the speech and language specialist was asked why these items were chosen she responded: "It was arbitrary; we just wanted him to learn to imitate."

The child's parents objected to his program whereupon school district officials brought a well-known consultant from another state. The consultant proclaimed the speech and language specialist "one of the best I have ever seen." In addition, she then assisted the staff in developing a new individualized educational plan (IEP) for the child without consulting the parents. The IEP included the objectives and goals found in Table 1 along with six other disconnected objectives (e.g., tracing letters of the alphabet). Subsequently, school district personnel and the consultant seemed surprised that the IEP was challenged by the parents.

Where And With Whom Are These Students Being Taught?

It is not infrequent for students with autism to be transported long distances in order to attend a homogeneous "autistic" classroom in a segregated, handicapped-only facility. Such arrangements preclude programming which involves non-handicapped peers and others. The students are seldom given the opportunity to generalize the skills they learn in school to other environments, and are rarely taught the skills necessary to survive independently or semi-independently in non-school environments.

When Are These Students Being Taught?

Classroom schedules often provide good indications of how staff prioritize the skills their students need to learn. Recently, a major educational agency published guidelines for school districts which would be developing classrooms for students with autism. The suggested schedule for classrooms which would serve these students is presented in Table 2. (Since this publication has been recalled, the citation has been omitted). Following such a schedule, it seems assured that, after 11,340 hours of educational opportunity over 12 years of schooling, the students would realize 1,800 hours of bathroom; 2,340 hours of snack, choices, circles, and goodbye's; 2,880 hours of playground; and assuming that "centers" equals "instruction," 2,520 hours or 2-2/3 years of instruction. Unfortunately, approximations of such a schedule can be found in too many classrooms for students with autism and other severely handicapping conditions.

AN HISTORICAL OVERVIEW

If the examples presented above were unique or isolated instances, they could be dismissed as tragic aberrations of the educational system. Rather than being exceptions, these samples are unfortunately representative. It is critical that educators ask why. Why are available technologies not being applied appropriately in a wider variety of settings? Why are curricula so artificial and nonfunctional? Why is it that students with autism often attend no regular school campuses nor enjoy systematic interactions with non-handicapped peers? Why is programming for severely handicapped students often so unrelated to vital life functioning? An examination of the history of public education in America and the history of research in the field of autism itself provides some insight into current educational shortcomings.

The Nature Of The Public Education Model In The United States

Recent legislation governing the education of handicapped children has imposed a myriad of new requirements on the public educational system. Such requirements include, for example, individual assessment followed by placement according to an individual educational plan which is to reflect the unique needs of each child, as determined at least by parents, teachers, administrators, and the child, if appropriate. Contrary to these demands, the implicit and explicit direction of our public school system since the beginning of this century has been toward a model that fits the "myth of the melting pot" and that leaves all educational decision-making in the hands of the professionals. Real individualization and lay input into decision-making have been alien to the system (Iannoccone, 1979). Setting objectives and choosing activities thus become a pro forma exercise to fit into the already determined classroom schedule. The system continues to behave in ways most familiar to it, with little understanding of the real intent of recent legislation: namely, to consider unique needs for each student.

Fortunately, many professionals are attempting to change the public educational model into one which is more responsive to the needs of individual learners. In the case of students with autism, however, educators often fall short because so little information has been available to them regarding the needs of these students and the characteristics of effective educational services. This has been due, at least in part, to the historical distance between autism research and the ongoing educational community.

Autism Research And Educational Services

In the past, when educators rejected persons with autism, the information and service void was filled by persons outside of education, particularly mental health workers and psychologists. As educators attempt to accommodate the needs of autistic students, there is little in their own profession in terms of direction, experience, curriculum strategies, or service delivery models to assist them. With the exception of a few fine books that address some of the learning needs of these students (e.g., Wing, 1974; Lettick, 1974), teachers and others must look to the research literature in behavioral psychology. School personnel who are attempting to assess the long-term educational needs of these students often find only medical, psychiatric, and psychometric research. Because of the episodic rather than longitudinal nature of this research, educators are likely to find little with direct application to the public school classroom.

Nature of research in autism. A review of the existing research literature in the field of autism reveals no data on longitudinal, comprehensive instructional approaches that could enable students to develop the skills actually needed to live, work, and play in complex and heterogeneous community environments. This is not to detract from the value of the research in the field. Tremendous progress has been made in twenty years and much of it is a direct result of that research. However, the approach to the solution of educational systems problems for autistic and other severely handicapped students has been limited. Typically, researchers in autism have focused on basic research questions. While such research may ultimately benefit large numbers of children in the future, it rarely provides direct assistance to the instructional and organizational problems facing a classroom teacher. A research may focus on a methodology to teach X without ever questioning or justifying the students' need to do or to know X. While a tension between basic and applied research is common in many fields, it is particularly so in autism, since most of the available educational services literature in the field has been generated by researchers.

Many contributions of researchers in the field of autism were made by people vitally interested in the diagnosis of, causes, and cures for the syndrome (e.g., Ornitz & Ritvo, 1968; Rimland, 1964; Rutter, 1968; Rutter, 1978; Schopler, 1978). Such lines of research were valuable in the past if only because they provided more parsimonious and plausible explanations than were generally offered by mental health personnel and psychoanalysts in particular (e.g., Bettelheim, 1967). Such research continues to be extremely valuable because of the critical need to find the biological basis of the syndrome, but is often less than relevant to the comprehensive educational needs of students with autism.

Perhaps, understandably, much of medical and psychiatric literature is concerned with finding a cure for autism. Even in the area of behavioral psychology, which has made outstanding contributions to the education of these students, the emphasis has been more on "curing" or "ameliorating" certain problems than on the design and implementation of long-term instructional services. The primary concerns of many behavioral psychologists have been oriented toward greater definitional precision and understanding of various facets of learning styles and characteristics, and the elimination of high-rate, socially unacceptable actions (e.g., Metz, 1965; Lovaas, Litrownik, & Mann, 1971;

Koegel & Schreibman, 1977). Psychological literature, therefore, is replete with demonstrations that some "subjects" with autism can learn isolated skills under circumscribed conditions. Similarly, there is much written about the deceleration of unacceptable behaviors. Given the saliency of many of these behaviors in terms of rate, durability, the physical danger they present to the child and others, and the interference with opportunities to develop other skills, it is certainly understandable why many professionals focus upon these characteristics. The literature demonstrating that autistic self-stimulatory and self-mutilating behaviors could be replaced with other less deviant actions, as well as research which looks at learning problems correlated with autism, offer tremendous contributions to the education of autistic students. Nevertheless, this literature is limited and, while it must continue, it should no longer confine or define behavioral research in the field of autism. Guess, Horner, Utley, Holvost, Maxon, Tucker, and Warren (1978) contend that, while the present technology of teaching severely handicapped students is far from complete, our current understanding of "how" to teach seems more advanced than our knowledge of "what" skills to teach and the sequence of teaching these skills.

Confronted with problems of the magnitude associated with autism, it is understandable that many researchers did not relate to questions of what skills were being taught, the rationale for their selection, or the characteristics of instructional location or delivery. Consequently, these issues have often been ignored by conscientious teachers and others who, upon reading the behavioral literature, struggle to replicate research strategies, content, and measurement systems in the classroom without regard to the longitudinal needs of any given student. Too often educators have been unable to generalize from the research which demonstrates effective techniques (albeit with irrelevant content) to the utilization of those techniques in more educationally meaningful ways. Thus, there is often no theme or educational "gestalt" to programs provided for individuals with autism. Rather, the educational services often consist of disjointed, functionally irrelevent "behavioral targets."

THE NEED FOR NEW STRATEGIES IN DEVELOPING PROGRAMS FOR STUDENTS WITH AUTISM

It is time to begin to address broader issues regarding the education of students with autism and to begin to identify other informational needs to the scientific community. Educational services for these and other severely handicapped students must be based upon more than presently available research. Again, this is not to diminish the value of the research that has been done to date. In many cases, to replicate the materials, teaching strategies, tasks, and objectives used by the researcher is counterproductive to the educational needs of the children served. While there is certainly the technology to teach a child to identify a cup, draw a triangle, count backward, and discriminate blue from purple (Koegel, Glahn, & Nieminen, 1978), the telling question for the educator is: "So what?". So what if Johnny can touch three sequenced red, white, and blue blocks--if he cannot tell his mother what he wants for supper, cannot act appropriately on a public bus, and cannot play a simple game with peers or siblings?

Available research provides convincing evidence that:

1. Students with autism can learn many skills (Lovaas, 1977);

2. Students with autism can be taught to perform in response to cues from a wide variety of persons (Koegel, Russo, & Rincover, 1977);

3. Students with autism have poor generalization skills and must be taught in a variety of settings to ensure that desired skills will be performed in those settings (Koegel, Glahn, & Nieminen, 1979);

4. It is possible to teach a wide variety of personnel to deal with persons with autism, thus providing students with autism access to a greater variety of living and learning environments (Donnellan, LaVigna, Schuler, & Woodward, 1979);

5. It is relatively easy to attract large numbers of people to work with these students (Warren, 1980);

6. Autistic and other severely handicapped students can be taught age-appropriate and functional skills in natural environments (Goetz, Schuler, & Sailor, 1979).

On the other hand, data also show that 95 percent of adults with autism live their lives in the back wards of large multipurpose and dehumanizing institutions (Sullivan, 1977). The socio-political implications of why and how our nation has chosen an institutional mode as the primary domestic environment for so many handicapped people is discussed elsewhere (Wolfsenberger, 1972) and is beyond the scope of this paper. Instead, it is the purpose of this paper to address the issues of what educators can do to change the outcome for these students. Lotter (1974), in his Middlesex follow-up study, said that he was unable to find any noticeable effect of educational intervention on the subjects of that study. Yet, we as educators are convinced that education can make a difference (Fenichel, 1974). It is the purpose of this paper to identify some of the dimensions that must be addressed if educators are to begin to provide longitudinal and comprehensive educational services that are systematically and functionally relevant to the enhancement of the ultimate life space and functioning and, therefore, the quality of life of all persons with autism.

Tomorrow morning a child will be identified as having the problem of autism. The challenge to the educator is to ensure that this child does not end up 15 years from now in the same depersonalized and dehumanizing institutional environment as his or her categorical predecessors. The remainder of this paper will delineate some of those critical dimensions of services to students with autism.

CRITICAL EDUCATIONAL DIMENSIONS OF ACCEPTABLE EDUCATIONAL SERVICES

Since the majority of children with autism currently grow up to be adults who live in institutions, one criterion of educational change would be a significant increase in the number of students with autism who are able to participate successfully in a variety of community-based environments as adults. Brown, Nietupski, and Hamre-Nietupski (1976) referred to such a goal as the "criterion of ultimate functioning," a dynamic and fluid, yet specified and personalized, set of attributes that each person must have in order to function at maximum potential in adult community environments that are socially, vocationally, and domestically integrated. Obviously, a number of dimensions can contribute to success in effecting competent community performance by adults with severe handicapping conditions.

How And Where Students Are Taught

Instructional setting. Most programs for students with autism operate on the assumption that the classroom setting is the best place to teach most skills and that excursions beyond the classroom are "field trips" designed to "expose students to other experiences." This assumption neglects to take into account the significant generalization problems demonstrated by autistic and other severely handicapped students as shown in the chapter by Carr (1980). Koegel, Egel, and Dunlap (1979), in commenting on the experience of mainstreaming students with autism, note that one of the principal advantages of placing such students in environments containing non-handicapped students is that it enables educators to discern the wide range of important skills these students need yet to learn. They maintain that this practice may be a moral obligation, inasmuch as it helps to showcase the most productive target behaviors for their successful development, in addition to revealing the potential that many of them have for functioning successfully in the regular classroom.

Since it is obvious that none of these students will spend his or her adult life in a classroom, it is necessary to develop curricula that relate to teaching functional skills in at least such areas or domains as community functioning, domestic living, recreation/leisure, vocational functioning, and social interactions with non-handicapped peers. To implement meaningful programming in these areas, a significant portion of the educational experience ought to take place in the varied school and non-school environments in which they will ultimately live, work, and recreate. It is strongly urged that the notion of an "instructional setting" be expanded to include direct, systematic, longitudinal, and comprehensive instruction in a variety of non-classroom and non-school environments. The older the student becomes, the less time they should spend on school grounds and the more time they should spend in shopping centers, buses, and bowling alleys, not as passive recipients of a field trip experience but as learners who are gaining the skills needed to function in those environments. If, as Dunlap, Koegel, and Egel (1979) suggest, there is an obligation to assist students with autism in learning to adapt to normal classrooms, then there certainly must be an obligation to assist them in dealing with the natural environments in which they will ultimately be required to function.

Instructional arrangements. The extraordinary behavior and learning problems of students with autism usually require that classrooms have low teacher-student ratios. Unfortunately, many persons have interpreted this to mean that the ideal for these students is a one-to-one interaction with a teacher throughout the day. While there is no doubt that this kind of individualization will be required to teach some skills to some students under certain circumstances, educators must also be aware of the need to teach the students the skills necessary to interact with persons other than instructional personnel and to function effectively within groups. A good educational environment should contain a wide variety of instructional options, including one-to-one individualized instruction within small groups, student-to-student arrangements, and peer model-to-student arrangements (Donnellan, Falvey, Pumpian, Baumgart, Schroeder, & Brown, 1980).

Instructional technology. The learning and behavior problems presented by students with autism have contributed to the development, application, and refinement of some relatively precise technologies which can be used to enhance the probability that a given student will acquire the skills that he or she needs to learn. The discrete trial format (Koegel, Russo, & Rincover, 1977), from the field of applied behavior analysis, is a good example. It has been demonstrated that such technology can be taught to a variety of professionals and non-professionals (Koegel, Russo, & Rincover, 1977; Donnellan-Walsh & Schuler, 1977; Donnellan, LaVigna, Schuler, & Woodward, 1979). However, this technology is associated with several potential limitations when referenced against the criterion of ultimate functioning. The very precision of the technology, the specification of stimulus cues, may preclude the student from responding with similar behavior in less precisely delineated environments. Vincent, Salisbury, Walter, Brown, Gruenewald, and Powers (in press) comment on this concern relative to the transition of young handicapped children from early childhood special education into regular education. According to these authors, while technology may clearly produce positive changes in children's performance, the literature shows that changes displayed under specific learning conditions do not easily generalize to other, more natural environments (Stokes & Baer, 1977). Thus, children may be learning to produce a behavior only in relation to highly specific antecedent and consequent conditions that do not exist in other environments. There is no doubt that highly specialized technology is necessary; it is its application and direction that should be questioned, inasmuch as the focus of special education should be to remove the technology while continuing to maintain the child's response.

One solution to this problem is to teach the technology to a wider variety of people in the child's natural environment (Koegel, et. al., 1980). While this may in fact be a valid strategy for teaching a specific student a specific skill, it may not always be feasible. Educators are responsible for large numbers of students whose parents, siblings, and friends may not have the resources, inclination, skills, nor time to participate in such training. Obviously educational efforts cannot be confined to those children whose parents and others are cooperative. The solution is not to ignore the technology and all the benefits it has achieved, but rather to adapt the technology to more natural, less artificial learning and living environments.

Applied behavioral analysis in natural settings. Many educators encourage and support applied behavioral research in natural settings (Neff, Iwata, & Page, 1978; Yeaton & Bailey, 1978). Unfortunately, such research is not prevalent in the area of autism, where most research comes from clinical or institutional settings or from simulated classroom models (Dunlap, Koegel, & Egel, 1979). Such environments do not take into account the multiple agendas that operate on a typical public school class. There are multiple public and private levels of operation, including such matters as processing subject matter information, judging student abilities, managing classroom groups, coping with emotional responses to events and behaviors, establishing procedures for routing and special assignments, distributing resources and supplies, keeping records, interacting with colleagues and administrators, and many other tasks. In special education, the "many other tasks" include activities not typically found in regular education (training aides, meeting with ancillary staff, evaluating IEP's, having conferences with parents, and so on). In real schools, difficult children cannot be assigned to a spare graduate student nor sent back to the ward as often occurs in research classrooms. The typical special education classroom, however, is itself artificial compared to natural non-classroom environments. Field research in a wide variety of natural settings would facilitate identification of the behavioral strategies necessary to better assist teachers in working with autistic students. Many of the strategies are already well documented but are not typically known by teachers of autistic students. For example, teachers of autistic and other severely handicapped students must broaden the measurement strategies at their disposal. Trial-by-trial or event-data collection may be feasible and appropriate for teachint "table tasks" in one-to-one or small group arrangements. However, strategies must be developed to monitor student performance on more complex tasks in less controlled settings. While a student may correctly board the front of the public bus on five consecutive trials, he may do it so slowly that it is unacceptable to the general public. Teachers must be sensitive to monitoring all socially important dimensions of student behavior.

Alternatives to the use of punishment. Just as it is critical that a teaching technology be developed that can be used to teach functional skills in natural environments, it is critical to develop a technology that can be used to prevent, reduce, and eliminate a variety of aberrant behaviors in classrooms and in other settings. Irrespective of the legal and ethical issues involved (Martin, 1979; LaVigna & Donnellan-Walsh, 1976; LaVigna, 1980), more and more public schools are reluctant to allow the use of aversive stimulation or exclusion in the form of "timeout" to reduce serious social/behavior problems. Even if the schools allow aversive techniques, the use of such procedures may restrict the student to the school environment because many successful aversive interventions are not appropriate in bowling alleys and other public places. The result, therefore, may be that students with autism may not learn to behave appropriately in a variety of settings. A concerted effort must be made to find applications of the technology which are feasible and acceptable in a wide variety of settings.

Naturally occurring cues and prompts. Applied research in natural environments would facilitate the development of strategies to help autistic and other severely handicapped students to respond to naturally occurring stimuli and prompts (Donnellan, et. al., 1980; Falvey, et. al., 1980). While the literature typically tells teachers to "fade out prompts," there are no clear directions how to "fade in" those prompts on cues which are available to non-handicapped students. If teachers are to train their students to shop in supermarkets, then teachers need to know how to inventory such environments for naturally occurring cues, such as the actions or words of the cashier which signal that he is finished adding the bill and wants the money. Students who are being taught to swim at the local YMCA can be taught to respond to the cue that empty lockers are the ones without locks on them or that the swimming instructor blows the whistle when it is time to go into and out of the pool. Potential research questions related to generalization, stimulus overselectivity, and other learning characteristics are endless.

Repeated practice. Many teachers have been encouraged to teach to criteria in the context of massed trial or repeated practice formats. That is, teachers often feel the need or are encouraged from reading research literature to provide relatively large numbers of teaching trials in relatively short periods of time. However, it is an empirical question whether, for some kinds of learning, repeated practice strategies implemented in artificial settings might not actually impede the acquisition of concepts and operations. In other words, it is possible that teaching the appropriate label for "cup" by arranging ten opportunities to respond to questions such as "What is this?" and "What do we need to drink?" and to interact with cups by taking them out of the dishwasher, stacking them, drinking from them, and so on, might ultimately be preferable to ten or twenty two-choice discrimination trials where students are asked to "Show me cup?". A clear danger of the widespread use of repeated practice strategies is that teachers may limit their curriculum to those activities that readily lead themselves to massed trials, further encouraging the use of artificial tasks, materials, and settings. We do not wish to encourage more loosely structured instruction, but to teach teachers to systematically arrange for more naturally occurring learning situations.

Strategies For Deciding "What" To Teach Students With Autism

Rationale behind current curriculum development strategies. The activities presented in the typical classroom for children with autism are often irrelevant, non-functional and based on notions of curricular content which are best suited to normal pre-schoolers. Even if one ignores the weak and unstructured classrooms which seem to view these students as "emotionally disturbed" and look only to those which strive to more appropriately program for these children, one is still struck by the seeming irrationality of the choice of activities. This artificiality is so pervasive that it would seem to reflect some underlying notions or logic about curriculum development.

Guess and his colleagues (Guess, Horner, Utley, Holvoet, Maxon, Tucker, & Warren, 1978) have identified two kinds of logic. The first is *developmental logic* which follows cognitive theories of learning in assuming that the education of severely handicapped children should follow the sequence in which normal children learn. The second, *remedial logic*, advances the assumption that severely handicapped children are not the same in their abilities and deficits as normal children, and that their education should concentrate on identifying the skills and skill sequences that will improve the child's ability to interact successfully with his environment. Remedial logic also emphasizes the success of past efforts through which severely handicapped children learned difficult skills, and places little emphasis on their "readiness" to master each element.

Guess et. al., (1978) characterize developmental logic in terms of *horizontal* program sequencing, and remedial logic in terms of *vertical* program sequencing. Both approaches have strengths and weaknesses. According to the authors, developmental logic tends to focus too heavily on developmental states, and this, in turn, implies maturational determinants of behavioral acquisition and undue emphasis on readiness skills. The dependency of this approach on characteristics of the child makes it quite possible to rationalize failure as due to these characteristics, rather than to a failure of the curriculum or the teaching procedures. On the other hand, the vertical sequencing of remedial logic can lead the educator to assume that almost any behavior can be taught once it has been objectively identified, task analyzed, and flow charted. When this kind of over-confidence in our current technology fails to produce change in a child, its proponents may revert to a perceived need to teach more basic "prerequisite" skills, a response that corresponds to the emphasis on readiness skills proposed by the developmental approach. However, vertical sequencing does combine the technology for teaching with the optimism that skills _can_ be taught.

Strict adherence to either approach presents particular difficulties to students with autism, whose learning difficulties include developmental discontinuity, unusual rule learning skills (Hermalin, 1971), stimulus over-selectivity, and generalization problems (Carr, 1980). Students with autism and other severely handicapping conditions need a curriculum that is functional rather than artificial, integrated rather than isolated, longitudinal rather than episodic, and that has minimal reliance on instructional inference (Donnellan, Flavey, Pumpian, Baumgart, Schroeder, & Brown, 1980).

Of course, any activity can be seen to have potential functional value, particularly if one relies on a "readiness" model. In the earlier example where a child was assigned the additional IEP goal, "to trace all of the letters of the alphabet," school officials argued that this would "make him ready for the normal classroom." Given the disparity between his skills and the comprehensive demands of a regular classroom placement, it is highly unlikely that mastery of this skill alone would have supported placement in the regular classroom.

In deciding whether to target a particular skill for training, teachers and parents should ask, "If this child does not learn to perform this skill, will someone have to do it for him?" For example, "If he does not learn to put together one more five-piece formboard, will someone have to do these things for him?". Probably not. However, if he does not learn to cut the food on his plate, put the coin in the vending machine, or put on his shirts, someone will have to do these things for him. Of course, not every activity can be judged by this definition; there are single-person leisure time activities such as playing solitaire or listening to music which are probably better judged by other standards such as "normalization" (Wolfensberger, 1972). The definition is, however, a simple and efficient way of judging relative functionality, particularly as students enter adolescence and young adulthood.

Organizing curricular content. In addition to a greater emphasis on functionality in curricula for students with autism, alternatives to the popular approach of categorizing curricula into discrete content areas, such as gross motor, self-help, and language, must be developed. These areas are not, in fact, discrete, and such categorization often leads teachers to think about a student's day in a disjointed and fragmented manner. This fragmentation places the burden of synthesizing the various daily activities on the student whose acquisition and performance problems are often defined by the absence of or by deficiencies in the ability to synthesize information from a variety of sources.

One alternative strategy for generating and organizing educational curricula for severely handicapped students is the ecological inventory strategy described by Brown, Branston, Hamre-Nietupski, Pumpian, Certo, and Gruenewald (1979). This approach is particularly appropriate for meeting the unique needs of students with autism and the reader is referred to their work for an in-depth presentation of the strategy. Briefly, they suggest the following steps:

1. Divide the curriculum into the most relevant curricular domains;
2. For each domain, identify the environments in which a severely handicapped student is functioning or might function in the future;
3. Divide the environments delineated in each domain into subenvironments;
4. Delineate the activities that occur in each sub-environment; and
5. Delineate the specific skills needed in order for severely handicapped students to participate in as many of the activities as possible.

Rather than working with traditional developmental curriculum domains, Brown, Falvey, Vincent, Kaye, Johnson, Ferrara-Parrish and Gruenewald (1979) suggest domestic, vocational, recreational/leisure, community functioning, and interaction with non-handicapped persons as non-mutually exclusive curriculum domains and recommend that each be represented in the IEP of each student. Within each domain, the current and subsequent environments which are presently available or could be potentially available to the student should be studied in detail. This ecological inventory of current and subsequent environments would include at least the following steps:

1. Conduct a non-handicapped person inventory including analysis of skills used by the non-handicapped to function in a particular environment;
2. Conduct a severely handicapped person inventory including a determination of the precise skills necessary for a given severely handicapped student to participate in the activities which take place in that environment; and

3. Conduct a discrepancy analysis comparing the skills manifested by the non-handicapped and the present skill level of the handicapped student.

The information generated by this kind of analysis would provide critical information concerning the skills on which the student needs instruction in order to participate in appropriate activities. It is this kind of information which would form the basis of the student's IEP goals and which would reflect present as well as long-term needs. This approach seems particularly appropriate for students with autism for several reasons:

1. Parents of children with autism often report that one of their greatest concerns is that their children have nothing to do when they have free time (LaVigna & King, 1975);
2. Public community functioning activities are particularly appropriate for students with autism because of their insistence of the preservation of sameness (Kanner, 1943) and their need to function in the terribly inconsistent "real world";
3. Children with autism are such rote and ritualistic performers that an emphasis on subsequent environments is necessary if alternative environments will ever be open to them.

The use of alternative approaches to curriculum development such as the "ecological inventory strategy" to assist in the development of individualized curricula will force us to re-examine our notions about instructional environments and settings in ways which will better accommodate to the generalization problems and other cognitive and social deficits of students with autism.

The Location Of Educational Settings

Historically, when children with autism were excluded from public schools, their parents joined other advocates to provide direct educational services and to work politically to obtain these services at public expense. The result of the first objective was that most programs for these children were private and, therefore, located in settings which were likely to be isolated from other, non-handicapped students. When the political efforts of the parents helped in the passage of legislation requiring that all children be educated at public expense, many parents were so accustomed to segregated educational service delivery models that they did not question when their child was placed in an "autism class" in the segregated handicapped-only school.

Programmatically, the position offered here is that there is not now, nor has there ever been, any inherent value in isolating this or any other population of students with handicaps. Isolation occurs for reasons other than the educational and social needs of students. According to O'Brien (1979), separate facilities for the handicapped can serve a political purpose in identifying what the district is doing "for" these individuals, thus impressing parents, legislators, and the citizenry in ways that can lead to approval of dollar appropriations. Isolation of handicapped people can also be done in the name of convenience, allowing professionals to centralize special services in the mistaken belief that it is more convenient for adults to move children. Isolation can also suit administrative purposes, in the sense that it may be easier to monitor one or two places that are responsible for special children than to monitor the education of these children all over town. Isolation may also continue to seem appropriate to those who continue to rely on yesterday's solutions because they are slow to change.

For handicapped students to be automatically segregated is stigmatizing, an impediment to their ability to function in desegregated environments, and a violation of their civil rights under the "least restrictive alternative" provision of PL 93-312, Section 504 (Martin, 1979). More specifically, there is substantial data and experience to indicate that students with autism have socialization deficits and have some difficulty generalizing from "treatment" to "non-treatment environments." If the criterion for choosing a setting is the development of a program which will maximize the possibilitythat the children served will be able to live their lives as members of the public community, then the preparatory experiences, including the location of services, should approximate characteristics of that community as much as possible. There is no programmatic rationale for a segregated environment or for homogeneous grouping. Unfortunately, for the moment the homogeneous grouping of five or six or more students with autism may be necessary because of the limited numbers of trained staff. However, alternative solutions must be designed and implemented immediately. Although there are no data indicating that students with autism are likely to learn normalized social relationships from each other, there is a great deal of evidence from parents that siblings and friends often do relate to and develop affectionate relationships with these children.

Although homogeneous grouping may be temporarily necessary, there is no acceptable rationale for segregated environments. Classes for students with autism ought to be in the same educational facilities as those of their non-handicapped chronological age peers. It is both stigmatizing and inappropriate to place a class of adolescents with autism down the hall with the normal kindergarten. If students with autism are to learn to act appropriately, they must have access to people and environments that demand appropriate behavior.

Similarly, if future citizens are to be more tolerant of the unusual behavior these children often exhibit, they need to learn early and often that what is unusual need not be frightening and probably is not dangerous. The normal schoolmates of these students have a good chance of becoming substantially handicapped themselves (Brattgard, 1977), or of becoming the parents of severely handicapped children. Certainly they have the right to learn about citizens who might look or behave differently. The Constitution does not demand that people like one another, but it does require that they tolerate one another (Galloway, 1979).

Some would argue that the success of many fine private programs for students with autism justifies their education in isolated settings. The counter is, of course, that private programs for children with handicaps have typically rated their success on their ability to return a percentage of their students to less restrictive environments. Moreover, the issue is not private vs. public; it is the elimination of the automatic, arbitrary, unnecessary, and counterproductive segregation of these students. There is every reason to believe that, if the skills, technology, and experience of these private programs were available in chronological age-appropriate, desegregated school settings, the success rate and the lives of these students would be enhanced. Past models and solutions clearly are not sufficient if educators are to make the difference, ultimately, in the life space of these students. Perhaps seemingly radical solutions must be tried. At least one major non-public school program for children with autism, Division TEACCH out of the University of North Carolina, described in the chapter by Olley (1980), has been successful in operating many classrooms for these students in regular public school buildings. The governance, funding, policy issues, and so on, are of course unusual, but the needs of this population as well as the problems of declining resources and enrollment which face the larger educational community today may argue for many more radical, flexible, and unusual solutions.

IMPLICATIONS FOR PERSONNEL PREPARATION

Status Of Personnel Preparation

Generally, personnel preparation in the field of autism has been inadequate. Depending upon the area of the country, training programs are wither nonexistent or inappropriate. The absence of training programs is attributable to the fact that, since students with autism were for so long excluded from public schools, there was no reason for personnel preparation programs to deal in depth with the educational programs of autism. A study conducted by Smith (1977) found that there were very few preservice or inservice training programs which prepare teachers in the area of autism. Recently, legal mandates requiring states to educate all children have caused teacher training programs to begin to deal with the needs of autistic children. Many of these emerging programs, however, fail to prepare teachers with the skills necessary to work with autistic children and youth. One reason for this may be the fact that autism is a low-incidence disability and usually subsumed by a larger category in most training programs. Frequently, autism is erroneously viewed as an emotional disturbance, and potential teachers of students with autism are prepared in the same manner as potential teachers of students who are emotionally disturbed. Such a course of training is not likely to equip teachers with the skills necessary to manage stereotypic or self-destructive behavior, to build communication, or to teach basic social interaction skills.

Presently, most teachers of students with autism receive their training in emotional disturbance, learning disabilities, behavior disorders, or some other category in which the student population is more mildly impaired than are autistic students. Smith (1979) found that the majority of teachers she surveyed did not feel adequately prepared to work with the autistic students who were in their classes. Such an unfortunate finding is understandable for a number of reasons.

First, it is not appropriate to train teachers of autistic classes as part of a teacher training program in *emotional disturbance* because the target children are not emotionally disturbed. Instead, they have severe, organically based cognitive and linguistic deficits, which are present at or shortly after birth and which are likely to last throughout life (Ritvo & Freeman, 1977; Warren, 1980). The educational needs of children with autism have little in common with most of the other students who are labeled emotionally disturbed. Although many "intellectually normal" students with autism share many characteristics and academic needs with mildly impaired populations and often may be appropriately placed in classes for the mildly handicapped, their needs remain more comprehensive and extend beyond the classroom setting.

Second, although students with autism are likely to exhibit many bizarre and even dangerous behaviors, placing primary emphasis upon these behavior disorders does not relate to critical comprehensive habilitative needs. Teachers must also know how to deal with the cognitive, communication, social, vocational, community functioning, and other needs which are usually quite different from the needs of other students who, for example, may be referred out of their regular classrooms primarily because of "acting out" behavior.

Since teacher certification is closely linked to the way the public officials categorize children, it will be necessary to remove autism from the emotional disturbance, learning handicapped, or other inappropriate category in which it is presently found in federal and state regulations in order to impact significantly on training. The question of whether autism should be a separate category or be part of a broader category, but one which more adequately reflects the needs of these students, is an important one (Warren, 1980) with wide-ranging political and educational consequences.

The concern here is that teacher trainers may not generalize from this circumscribed information to the more comprehensive needs of teachers. If one views teacher training in terms of the ultimate functioning of students, it is apparent that teachers need to learn the processes for identifying, assessing, promoting, monitoring, and evaluating comprehensive and longitudinal goals that each of their students must possess now, and in the future, in order to succeed in a heterogeneous post-school society. Taking such an approach, competencies such as those referred to above can help generate clusters of competencies which more adequately reflect the longitudinal and comprehensive needs of teachers and their students with autism.

Teachers who work with students with autism and other severely handicapping conditions should possess at least the following competencies:

1. The ability to assess and document across a variety of activities and settings the student's learning strategies, performance, rate, and degree of generalization and stimulus control difficulties;

2. The ability to assess the particular language characteristics and communicative needs of an individual student and to develop appropriate programs which incorporate systematic language and communication development as part of all curriculum domains and instructional activities;

3. The ability to inventory a variety of current and future environments selected in consultation with parents and/or guardians, in order to identify important activities performed by non-handicapped persons;

4. The ability to identify and incorporate the natural cues and correction procedures on which non-handicapped persons rely;

5. The ability to inventory and analyze the skills necessary for a given student to perform in a wide variety of natural environments;

6. The ability to choose and prioritize, in consultation with parents or guardians, a variety of instructional activities which will enhance the ability of each student to perform effectively in the natural environments delineated;

7. The ability to coordinate the unique needs of all of the students in the class so that the class can function as a whole, yet meet the needs of each student;

8. The ability to use a variety of instructional strategies to effect student learning;

9. The ability to use a range of appropriate behavioral management strategies with due consideration given to the legal, ethical, and administrative issues involved, as well as to the natural environments in which the strategies might have to be implemented;

10. The ability to monitor student progress and to make program decisions based on data collected in a variety of school and non-school environments;

11. The ability to select clusters of activities so that the individual student can use what is learned in one activity or environment to enhance his learning in another.

Where Should Teachers Of Autistic Students Be Trained?

It is often argued that teachers of students with autism should be trained in the schools and communities as close as possible to those in which they will work because it is into those schools and communities they will be integrating and training their students. For example, it seems appropriate to inservice each teacher with his or her own students, student teacher aides, administrators, and ancillary staff. However, as there are so few teacher training programs and such a great need on both preservice and inservice levels, such a strategy seems impossible.

In preservice training, the experience of the classroom itself has tremendous influence on student teacher behavior, even to the point of shaping student teachers in ways that are not in keeping with what they are learning in university lecture halls (Iannoccone & Button, 1964; Copeland, 1979). This, coupled with the fact that student teachers need the opportunity to practice what they are learning with actual children, suggests that inservice and preservice training needs cannot be clearly separated. The Rand report on federal support for educational change (Berman, 1973-1978) suggests that long-lasting change in educational programming is highly dependent upon local school conditions. Packaged materials and dependence on external consultants to change teacher behavior do not result in enduring change unless the change is adapted to local needs. A study of California's early childhood program (Baker, 1976) similarly concluded that state programming policy would receive only lip service attention unless the people on site were willing to adopt the policy and unless the innovations met local needs and conditions. "Hands on" training has been shown to be highly successful when teaching teachers, aides, speech and language specialists, administrators, and other school personnel the technology necessary to work effectively with autistic students (Koegel, Russo, & Rincover, 1977; Donnellan-Walsh & Schuler, 1977). In addition, the skills necessary to train others in this technology can be taught to many naive persons. Part of the success of these projects was their adaptability to local needs.

It should be obvious that teachers who will be working with students having the problem of autism must have at their command most of the same competencies as those needed by teachers of other severely handicapped students since students with autism share a need for long-range, comprehensive, functional education in natural environments. Of course, the educational needs of students with autism and students with other severe handicaps are not totally congruent. For example, teachers of students with autism will probably not have to deal with many of the physical handicaps that are frequent among the severely handicapped. Similarly, teachers of physically or multi-handicapped students will seldom encounter the ritualistic compulsions, unusual learning styles, bizarre behaviors, or unusual language characteristics which are so often found in autism. Nevertheless, the field of the severely handicapped provides some delineation of the competencies needed to work successfully with autistic populations.

What Should We Teach Teachers Who Will Work With Students With Autism?

Many leaders in the field of education for severely handicapped students have identified teacher competencies that are necessary for working with students with autism. For example, Haring (1975) cites six minimum skills essential for teachers of the severely handicapped:

1. The ability to task analyze and sequence the instructional curriculum with prerequisite, intermediate and terminal behaviors specified for each skill;
2. The ability to record and evaluate student progress on a daily basis;
3. The ability to select, purchase and construct and/or design special instructional materials;
4. The ability to teach and maintain attention and responses using reinforcement contingencies;
5. The ability to work with parents; and
6. the ability to function as a member of an interdisciplinary team.

According to Smith (1979), with minor variations, similar competencies or competency lists were suggested or developed by Allen, 1976; Perske and Smith, 1977; Scheuerman, 1976; Sontag, Burke and York, 1976; Stainback, Stainback and Maurer, 1976; and Wilcox, 1977. These lists of teacher competencies, while usually excellent, tend to reflect a clinical or "target skill" approach to teaching. Hopefully, many educators will take them and incorporate them into the broad range of skills necessary for teaching students in school and non-school environments.

It is reasonable to assume that such a hands-on and locally adapted model could be expanded to include a wide variety of the processes and skills teachers need to acquire to meet the comprehensive needs of students with autism. Using a field-based training approach, we could then identify persons and programs that are on the cutting edge of the education of students with autism and other severe handicaps and with them develop regional training institutes. The purpose of the regional institutes would be to train university level personnel who are doing preservice training of teachers as well as state department of education personnel who are responsible for identifying and disseminating "promising new practices" in the field of education. These trainees would then be responsible for inservice and preservice training on the local level through State Departments of Education and local universities.

In order for this or any approach to be successful, care would have to be taken to ensure that any one approach is not seen as "the model" or training package but one that teaches school personnel how to utilize processes and techniques which have been identified as successful with other autistic and severely handicapped students, and to adapt them to the individual and unique needs of the students in their local programs.

SUMMARY

This paper has reviewed education practices presently found in classrooms for students with autism. It is apparent that changes, including the development of more functional curricula; the location of classes in chronological age-appropriate, integrated settings; the use of age-appropriate and functional materials and naturally occurring cues and prompts; the expansion of classroom boundaries to include natural environments; and a rethinking of approaches to personnel preparation are necessary if society is to reverse the statistics which show that adults with autism are almost invariably condemned to lives in segregated institutions.

The efforts of educators alone will not be sufficient to effect such wide-scale change. Real differences will not be felt until all who consider themselves advocates begin to challenge the political and economic realities which currently thwart and splinter efforts to make community living alternatives available for all of our citizens (see MacCoy, 1980). Educators have often abdicated their responsibility and, as a result, given credence to those who claim that students with autism cannot be taught to participate in society in any meaningful way. They must now accept responsibility to develop educational approaches which emphasize longitudinal, comprehensive functional educational programming and which utilize the best of what research has to offer. The scientific community must also be convinced that it is now time to move more research into natural settings. The task is difficult, but essential, if the vicious cycle of isolation, rejection, and wasted human potential is to be ended.

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The Behavior Evaluation Scale

Presentation by: Dr. Stephen B. McCarney
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RATIONALE AND OVERVIEW OF THE BES

The major concern about schools expressed by teachers and parents in recent years has consistently related to behavior problems and discipline (Gallup, 1982). At the same time, although conservative estimates of the prevalence of serious behavior disorders/emotional disturbance typically range from two to five percent, recent data indicate that the average percentage of children and adolescents served by special programs established for such students is less than one percent (Annual report to Congress, 1981) and as many as two-thirds of all behaviorally disordered students are unserved (Grosenick & Huntze, 1980). The scarcity of adequate assessment instruments in the behavioral domain undoubtedly has contributed to the failure of the educational system to address school-related behavior problems, despite mandates for services through federal and state legislation.

The Behavior Evaluation Scale (BES) was developed in response to numerous requests for such an instrument from school personnel who were experiencing difficulty in reaching and documenting decisions regarding diagnosis, placement, and programming for children and adolescents with behavior disorders/emotional disturbance. The BES was also designed to be used as a general behavior rating scale with any regular class or special education student who exhibits behavior problems which warrant assessment and intervention.

Uses of the BES

Specifically, the BES may be used for six primary purposes: (1) to screen for behavior problems, (2) to assess behavior for any referred student, (3) to assist in the diagnosis of behavior disorders/emotional disturbance, (4) to develop individual education programs for any student in need of special education services, (5) to document progress resulting from intervention, and (6) to collect data for research purposes.

Screening and Identification of Problems

Because the BES is designed for use primarily by classroom teachers who typically must initially identify problems, and due to the ease of administration and scoring procedures, the scale can be used for screening purposes by classroom teachers. When used for screening purposes, the BES generally would be used by a teacher to confirm suspected behavioral difficulties or to gather additional specific information before a referral for a comprehensive diagnostic evaluation is made.

Behavioral Assessment for Referred Students

The instrument can be used with any referred student who exhibits behavioral problems which are of concern to a teacher. Behavioral assessment is an integral component of any comprehensive diagnostic evaluation, regardless of handicapping condition. Behaviors assessed by the BES certainly are not unique to any handicapping condition, but rather may be exhibited by students within any categorical area of exceptionality, including learning disabilities, mental retardation, physical impairment, or other handicapping conditions. In order to develop an appropriate IEP for such students, behavioral assessment becomes a necessity.

Diagnosis of Behavior Disorders/Emotional Disturbance

The very few existing behavior rating scales which provide objective and relevant information required for educational purposes generally are not based directly upon specified eligibility criteria for behavior disorders/emotional disturbance reflected in existing definitions or legislation. Such rating scales may provide useful information regarding the behavioral status of students, but generally fail to assist school personnel in determining whether students meet the eligibility criteria contained in federal or state regulations and, therefore, may not contribute directly to decision-making relative to special education placement. Each of the items on the BES is distinctly associated with one of the five characteristics of behavior disorders/emotional disturbance included in one of the most widely used definitions (Bower, 1959) in federal and state regulations, including Public Law 94-142. Accordingly, BES results, in conjunction with other information, may be used to reach and substantiate a diagnosis of behavior disorders/emotional disturbance when appropriate.

Development of Individual Educational Programs

The BES is particularly useful for determining specific behavioral strengths and deficits for individual students. The obtained information can be translated directly into programmatic decisions pertaining to annual goals, short-term behavioral objectives, placement and grouping for instructional purposes, and selection of intervention strategies.

Documentation of Progress

The objective and precise scale of measurement included in the BES permits school personnel to document behavioral progress made by individual students. Since the scale does not involve items which are directly administered to students, the instrument may be used as frequently as necessary without concern for "learning" or "practice" effects which often impede efforts to document progress. The instrument is especially well-suited for annual re-evaluation of students in special programs or even more frequent program reviews as required by some school districts.

Data Collection in Behavioral Research Studies

Behavioral research studies require the use of valid and reliable data collection procedures which yield objective and quantifiable data regarding the frequency and severity of behaviors of concern. The format of the BES permits such accurate measurement of behaviors by classroom teachers and other school personnel who have direct and ongoing contact with students.

Characteristics of the BES

To achieve the stated purposes of the BES, the scale comprises the following characteristics:

- Items were developed and validated by classroom teachers and professionals in special education on the basis of the prevalence and severity of the designated behaviors.
- Both validity and reliability of the instrument have been clearly established for its stated purposes.
- Behaviors are rated using highly precise and objective quantifiers which do not require direct and continuous observational recording.
- The BES is designed for use with students at all grade levels (K-12)
- A simple procedure to derive local norms for the BES is described to enable school personnel to evaluate behavior on the basis of current community or district standards.
- National norms of behavior, based upon a sample of 1,018 subjects in ten different states, are provided for decision-making purposes.

- The amount of time necessary to administer the instrument is minimal (10-20 minutes).
- The scale is easily completed by teachers and other school personnel who have the greatest opportunity to observe behaviors of students.

Components of the BES

The entire BES package consists of a manual and a set of Student Record Forms which are used to evaluate individual students. A supplemental form, referred to as the BES Data Collection Form, can be used to gather precise frequency data based upon direct observation of the behaviors on the scale. This form provides a method to acquire on-going and exact documentation of the occurrence of any or all of the behaviors on the scale.

Items and Subscales

Items representing specific behaviors which can be observed and measured are included in the BES Student Record Form. Each item is associated with one of five subscales developed on the basis of five characteristics included in the following definition of behavior disorders/emotional disturbance:

> The term "seriously emotionally disturbed" (or "behaviorally disordered" in many states) refers to ". . . a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance:
>
> (1) An inability to learn which cannot be explained by intellectual, sensory, or health factors;
>
> (2) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
>
> (3) Inappropriate types of behavior or feelings under normal circumstances;
>
> (4) A general pervasive mood of unhappiness or depression; or
>
> (5) A tendency to develop physical symptoms or fears associated with personal or school problems" (Bower, 1959).

Ratings Used to Evaluate Behaviors

Items are rated using a scale that ranges from 1 (NEVER OR NOT OBSERVED) to 7 (CONTINUOUSLY THROUGHOUT THE DAY). The scale is calibrated on a continuum which provides specific and objective data regarding the frequency of occurrence of each behavior at a level which is feasible for classroom use.

It is recommended that classroom teachers, or school personnel who have primary teaching responsibilities with the student, assign the ratings to behaviors of their own students. This procedure simply enables the primary observers of students to be the primary sources of information relative to observed behaviors. As Bower and Lambert (1965) stated:

> One of the most important and useful kinds of information obtained by the school is the teacher's professional judgment of children's behavior. Teachers see children over a period of time in a variety of circumstances: in stress situations, at work and at play. Their judgment and observation have been sharpened by professional training and by day-to-day experience with the normal behavior of children. Often the teacher's rating can be the single most effective index of a pupil's growth and development. (p. 130)

However, BES administration procedures do not require direct and continuous observation and recording of behavior by school personnel. This is a particularly important feature considering the instructional responsibilities and other time-consuming activities required of teachers.

Student Record Form

The Student Record Form is the protocol containing the scale of items and other sections used for scoring and interpretation of results. When scoring the BES, the assigned ratings for each item are transferred to the appropriate designated spaces on the "Data Summary Sheet" of the Student

Record Form. Items on the "Data Summary Sheet" are grouped within "behavior clusters" according to the five characteristics included in the definition of behavior disorders/emotional disturbance. All items also have assigned weightings which reflect the degree of severity or seriousness of each respective behavior on the scale. Cumulative weighted scores are converted to standard scores for comparison with either national or locally-derived norms. In addition to the scale of items and the "Data Summary Sheet", the Student Record Form also contains the "BES Profile", the "Comments" section, and "Guidelines for Using the BES."

DEVELOPMENT OF THE BES

Item Selection and Analysis

The original item pool was generated by numerous teachers of behaviorally disordered students in Missouri in conjunction with the three authors. This list of 47 items was then provided to 80 special education teachers and related professional personnel in several school districts throughout Missouri who had decision-making resonsibilities relative to children and youth diagnosed as being in need of special services. These professionals were asked to (a) eliminate any of the 47 items they believed were inappropriate for the identification and evaluation of behavior prolems in students, (b) modify or re-word any items which could be stated in a clearer or more useful manner for school personnel, and (c) add any new items which they felt would assist in the identification and evaluation of behavior problems.

The recommendations made by this group of professionals were invaluable in developing the current version of the BES. Several items on the original scale were eliminated or combined with other items in response to suggestions made during this first review. Many new items pertaining to behaviors not originally included were added to the scale. Each of the items was then assigned by the authors, on the basis of face validity, to one of the five characteristics in the federal definition of behavior disorders/emotional disturbance included in PL 94-142.

The resulting version of the BES was subjected to field testing by 104 elementary and secondary level classroom teachers from eight different school districts throughout Missouri. Districts were selected from metropolitan, suburban, and rural areas and ranged in size from 400 to 10,000 students.

After the final scale of items was completed, weightings for each item were established by 240 teachers from all grade levels (K-12) in Missouri. Weightings were assigned by teachers on the basis of the perceived severity of the behavior represented by each item (numerical weightings increased as a function of the degree of severity or seriousness of behaviors). The items were then ranked from high to low according to their mean weighted values. The items which were ranked in the approximate bottom 20% received a weighting of 1, those ranked in the approximate middle 60% received a weighting of 2, and the items ranked in the approximate upper 20% received a weighting of 3. The validity of the established rankings was later confirmed through following the same procedure with an additional 108 teachers who participated in the national standardization of the BES.

During field testing, four separate item analyses were conducted using (1) unweighted scores for normally-achieving students, (2) weighted scores for normally-achieving students, (3) unweighted scores for students with behavior problems and (4) weighted scores for students with behavior problems. Following the final revision of the scale, a fifth major item analysis was performed using the entire standardization sample from ten states as subjects.

The point biserial correlation technique was used to establish the discriminating power of the items. This procedure, which involves correlating each item with the total scale or subscale score, is generally used to ensure internal consistency of scales. Anastasi (1976), in discussing such guidelines, contends that .2 or .3 coefficients are acceptable under some circumstances, if the coefficients are statistically significant.

When items were correlated with BES subscales during the final item analysis, only three items failed to meet the more conservative .3 criterion. Coefficients were also computed to measure the correlation between individual items and the entire scale of items. Again, only three items did not meet the more rigorous .3 standard; when the lower .2 criterion is applied, all items on the scale produced acceptable coefficients. The three items which yielded questionable discriminating powers were retained due to the authors' initial and primary commitment to the process of using items developed by classroom teachers and other school personnel As indicated by the medians and ranges of discriminating powers provided in Table 1, the statistical adequacy of the items included within the BES has been firmly established.

Insert Table 1

Standardization Procedures

Demographic Characteristics of the Sample

The standardization of the BES was performed from January through June of 1982. The normative sample included 1,018 students from ten states selected to provide representation of the four major geographical regions across the United States. An unselected sample of 311 regular classroom teachers administered the BES to randomly selected students from their classes. As shown in Table 2, the numbers of teachers and students who were involved in the standardization were distributed fairly evenly across all grade levels (K-12). This even distribution across grades was intentionally designed to ensure appropriateness of the norms for all grade levels.

Table 1

MEDIANS AND RANGES OF DISCRIMINATING POWERS FOR FIVE BES SUBSCALES
(Decimals Omitted)

BES Subscales	Median	Range
1. Learning Problems	77	73-81
2. Interpersonal Difficulties	59	14-77
3. Inappropriate Behaviors	59	20-82
4. Unhappiness/Depression	43	34-64
5. Physical Symptoms/Fears	44	32-55

Table 3 reveals that the demographic characteristics of the sample concerning sex, residence, race, geographic area, and occupational status of parents closely approximate the distribution of these characteristics within the United States population as reported in the *Statistical Abstract of the United States* (1980).

Insert Table 2

Insert Table 3

Types of Normative Data

Two types of normative scores may be obtained from the BES: subscale standard scores, and a standard quotient for the total scale. The standardization data initially were analyzed by grade level, since the authors had intended to provide separate normative tables for each grade. However, upon examination of the results of this analysis, it was apparent that meaningful differences did not exist across each of the grade levels. The raw score distributions for subscales across grade levels were also quite similar. This pattern of similarity is understandable since the entire process of item selection and analysis, as explained earlier, was designed to promote equal applicability of the scale for all grade levels. The behavioral constructs measured by the BES are not developmental, or "cumulative", in nature, but rather are manifested comparably throughout the school years. To obtain further confirmation that BES results are neither grade- nor age-related, correlations between raw scores and grade and age were computed for each subscale and for the total scale. As shown in Table 4, the obtained correlation

Table 2

DISTRIBUTION OF TEACHERS AND STUDENTS IN THE SAMPLE ACCORDING TO GRADE LEVEL

Grade Level	Teachers	Students
K	21	67
1	24	80
2	22	70
3	24	77
4	24	77
5	25	86
6	27	87
7	22	71
8	28	97
9	25	85
10	22	71
11	24	77
12	23	73
	n= 311	n=1,018

Table 3

CHARACTERISTICS OF STUDENTS IN THE STANDARDIZATION SAMPLE

Characteristics	Percentage of sample	Percentage of nation
Sex		
Male	55	49
Female	45	51
Residence		
Urban	76	73
Rural	24	27
Race		
White	90	86
Black	07	12
Other	03	02
Geographic area		
Northeast	14	22
North Central	34	27
South	37	33
West	15	19
Occupation of parents		
White-collar	46	51
Blue-collar	33	36
Other, not stated	21	15

coefficients indicate negligible relationships between BES results and both grade and age. Consequently, to facilitate ease of use for school personnel, data from the thirteen grade groupings were collapsed into single conversion tables representing the combined grades.

Insert Table 4

Reliability

The internal consistency of the BES was investigated to measure the degree to which the items on the scale pertain to the same construct. The Coefficient alpha (Cronbach, 1951) procedure, which is a derivation of the Kuder-Richardson Formula 20 with similarity to Hoyt's procedure, was employed to measure reliability in terms of overlapping variance among scale items. The Coefficient alphas, which were computed based upon the performance of the entire standardization sample, were also used to calculate the standard errors of measurement for the subscale standard scores and for the total scale quotient (see Table 5).

Insert Table 5

The Coefficient alphas obtained for each of the five subscales and for the total scale are reported in Table 6. Two of the subscale coefficients exceeded .90, one subscale coefficient was in the mid- .80 range, and two subscale coefficients were only slightly below the .80 range. The total scale coefficient reflecting the internal consistency of the combined items was .96. Since reliability coefficients of approximately .80 or above are generally considered adequate for a scale which is to be used with individual

Table 4

RELATIONSHIP BETWEEN BES RESULTS AND GRADE AND AGE

	BES Subscales					Total Scale (1-5)
	1	2	3	4	5	
Grade	-.14	-.07	-.10	-.05	-.12	-.11
Age	-.04	-.03	-.01	.02	-.06	-.03

Table 5

STANDARD ERRORS OF MEASUREMENT FOR THE BES SUBSCALE STANDARD SCORES AND TOTAL QUOTIENT

BES Subscales	Coefficients
1. Learning Problems	0.79
2. Interpersonal Difficulties	1.12
3. Inappropriate Behaviors	0.90
4. Unhappiness/Depression	1.47
5. Physical Symptoms/Fears	1.44
Total Scale	2.00

students (Newcomer & Hammill, 1982), the obtained results indicate acceptable internal consistency of the BES.

Insert Table 6

In addition to internal consistency, the test-retest reliability of the BES was also investigated to determine the stability of the obtained measures over time. In April of 1982, a total of 57 students from a Missouri school district were evaluated by 15 regular classroom teachers, with at least one teacher from each grade level from kindergarten through twelfth grade. The time interval between the first administration of the BES and the second administration of the scale was ten days. Correlation coefficients computed between the two sets of obtained scores for each of the five subscales and for the total scale all exceeded .97 and were all significant at the .001 level.

Validity

Content Validity

Salvia and Ysseldyke (1981) maintain that three facets of content should be considered: "the appropriateness of the types of items included, the completeness of the item sample, and the way in which the items assess the content" (p. 102). Content validity of the BES was established by the process initially used to construct the scale. Appropriateness of items was assured since all items were originally devised and subsequently validated by a large sample of classroom teachers and special education personnel with direct knowledge and expertise in the area of school-related behavior problems in children and youth. The original item list was subjected

Table 6

INTERNAL CONSISTENCY OF THE FIVE BES SUBSCALES AND THE TOTAL SCALE
(Decimals Omitted)

	Coefficients
1. Learning Problems	93
2. Interpersonal Difficulties	86
3. Inappropriate Behaviors	91
4. Unhappiness/Depression	76
5. Physical Symptoms/Fears	77
Total Scale	96

Table 7

RELATIONSHIP BETWEEN PERFORMANCE ON THE BES AND BRP TEACHER RATING SCALE FOR DIAGNOSED BD STUDENTS
(n=49)

Behavior Rating Profile	Behavior Evaluation Scale					
	Subscale 1	Subscale 2	Subscale 3	Subscale 4	Subscale 5	Total Scale
Teacher Rating Scale	.47**	.65**	.57**	.19	.26*	.64**

* p <.05

** p <.001

to two separate reviews by groups of 30 and 104 professionals who were asked to identify any additional behavior problems not included on the original list, thus assuring completeness of the scale.

Criterion-Related Validity

Criterion-related validity is investigated to determine the extent to which a scale correlates with a validated measure of the same or similar construct. Concurrent criterion-related validity was explored by examining the relationship between BES results and scores obtained from the Teacher Rating Scale of the Behavior Rating Profile (BRP) (Brown & Hammill, 1978). Forty-nine students (25 in the elementary grades and 24 in the secondary grades) who previously had been diagnosed as behaviorally disordered and placed in special education programs were included in the study.

As indicated in Table 7, three BES subscales yielded coefficients which exceeded the .001 level of confidence when correlated with the BRP Teacher Rating Scale. One BES subscale produced results which were significant at the .05 level, and one subscale did not correlate significantly with the Teacher Rating Scale. The correlation between the total BES and the BRP Teacher Rating Scale was .64 ($p. < .001$). Examination of the items contained on the Teacher Rating Scale clearly reveals why this BRP scale does not correlate well with Subscale 4 on the BES. The BRP Teacher Rating Scale contains few, if any, items intended to measure behaviors directly related to the fourth characteristic ("A general pervasive mood of unhappiness or depression") described in the definition of behavior disorders/emotional disturbance on which Subscale 4 of the BES is based. In total, five of the six obtained coefficients were statistically significant, and four of the six coefficients, including the total scale coefficient, exceeded the levels of acceptability (generally in the .30 to .35 range) preferred by authorities (e.g., Guilford, 1956). These coefficients, representing conservative estimates of relationship since they were not corrected for attenuation, are clearly supportive of the concurrent criterion-related validity of the BES.

Insert Table 7

Construct Validity

The construct validity of an instrument pertains to the extent to which it yields results which are in accordance with the theoretical construct the instrument intends to measure. Three aspects of construct validity were investigated: (1) diagnostic validity, (2) subscale interrelationships, and (3) item validity.

The BES was administered to a sample of 49 students (25 elementary students and 24 secondary students from seven districts across Missouri) who had been diagnosed as behaviorally disordered (BD) and who were receiving special education services. Results from this sample were compared with scores obtained by a group of 49 regular class students randomly selected from the standardization sample. Mean subscale standard score differences between the two groups are depicted in Figure 1. In addition, the diagnosed BD sample obtained a mean total Behavior Quotient of 68, compared with the mean Behavior Quotient of 98 obtained by the sample of regular class students. Raw score mean differences between the two groups were statistically significant ($p. < .001$) for all five subscales and for the total scale as indicated

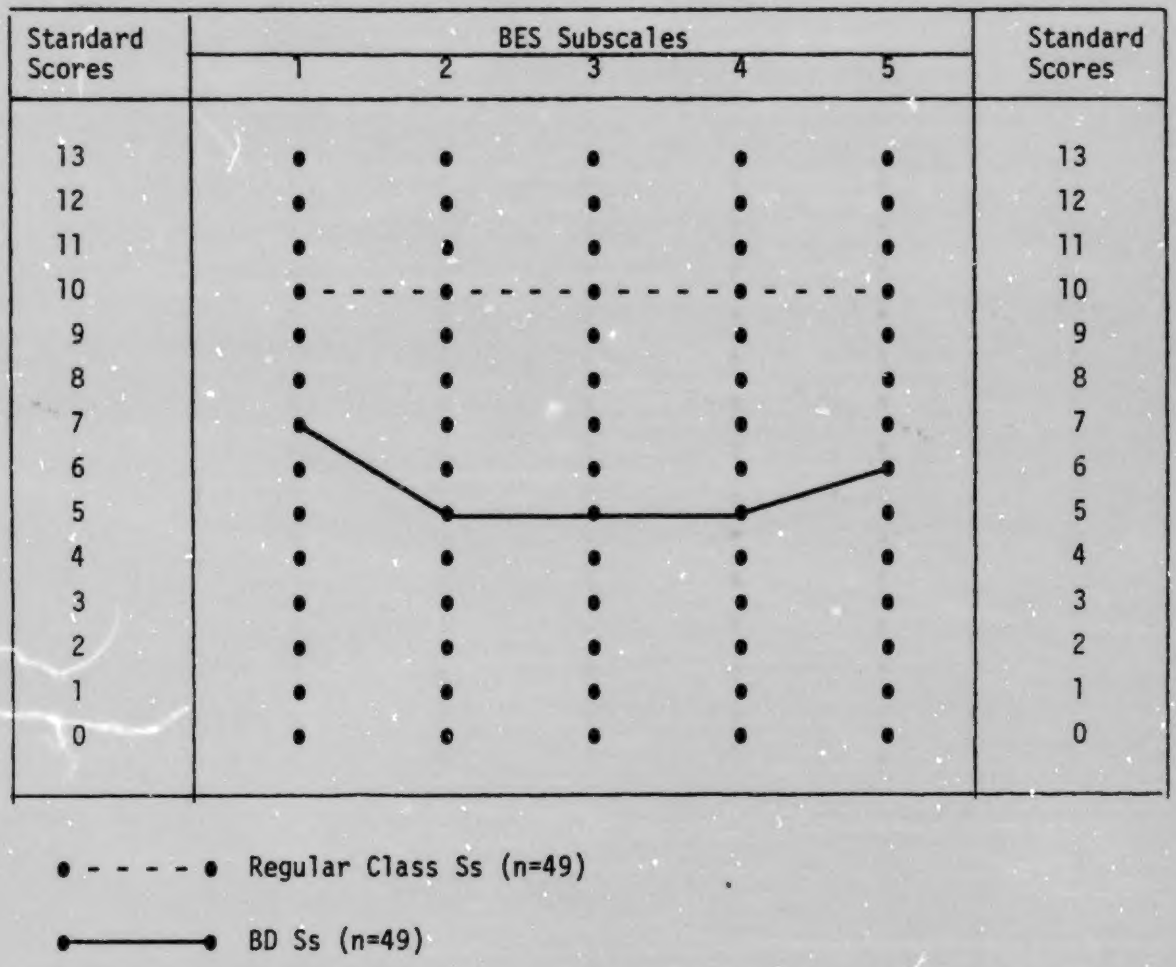

Figure 1

Comparison of BES Performance for Regular Class Sample and Diagnosed BD Sample by *t*-tests. These results, in conjunction with the correlation between the BES and BRP reported in the previous section, indicated that the BES possesses strong diagnostic validity for one of its stated purposes of assisting in the differentiation between BD and non-BD students.

If each of the subscales on the BES pertains to the construct of "behavior", then the subscales should correlate to a significant extent with each other. The size and statistical significance of the coefficients reported in Table 8 demonstrate that the subscales all measure the general construct of "behavior", and, furthermore, measure different aspects of the construct, since extremely high coefficients (e.g.,$>.90$) would suggest that all subscales were so interrelated that they measured essentially identical domains. Accordingly, the contention that the BES provides assessment information regarding five components of the behavioral construct is supported.

Insert Table 8

Finally, the discriminating powers of the items on the scale, as discussed earlier in this chapter (see Table 1), provide additional support for the construct validity of the BES. Since item performance correlates well with total scale performance, the internal cohesiveness of the BES as a measure of behavior is substantiated.

Table 8

INTERCORRELATIONS OF THE FIVE BES SUBSCALES*
(n=943)

BES Subscales	1	2	3	4	5
1. Learning Problems	---	.58	.71	.53	.50
2. Interpersonal Difficulties		---	.85	.71	.62
3. Inappropriate Behaviors			---	.69	.65
4. Unhappiness/Depression				---	.68
5. Physical Symptoms/Fears					---
Total Scale					

* All coefficients $p < .001$

ADMINISTRATION OF THE BES

Eligibility Criteria for Students

Because of the thoroughness of the normative procedures used to standardize the BES, the scale can be used with students from kindergarten through twelfth grade. The standardization sample consisted of 1,018 students across all grade levels from ten different states representing each of the four major geographical regions in the United States.

While BES results, in conjunction with other information, may be used to reach and substantiate a diagnosis of behavior disorders/emotional disturbance, the obtained data will certainly be useful in making decisions pertaining to eligibility, placement, or programming for any student who might require special services. For example, even though a multidisciplinary evaluation team might determine that the primary handicapping condition of a student is a learning disability, the information derived from the BES would be extremely useful in developing a behavioral component of an individualized education program.

Qualifications for Administering the BES

Although final scoring using the Data Summary Sheet can be performed by other school personnel, the BES ratings should be assigned by the classroom teacher or school personnel who have primary instructional responsibilities with the student. As stated earlier, the scale is based upon the premise that teachers and other professionals with the greatest opportunities to observe a student's behavior at varying times and in differing contexts should serve as a primary source of information relative to behaviors of concern. All professionals must, of course, use the BES in accordance with accepted standards and ethics associated with test administration, interpretation, confidentiality, and nondiscriminatory assessment practices.

Time Required to Complete the BES

Approximately ten to twenty minutes typically are required to complete the scale. The teacher does not have to record data while directly observing the student; ratings can be assigned to items at the teacher's convenience based upon previous observation and knowledge of the student. It is recommended, however, that the teacher complete the scale as soon as possible after beginning, so that results can be interpreted in relation to a specific and reasonable period of time.

Since the definition of behavior disorders/emotional disturbance states the characteristics must be exhibited ". . . over a long period of time . . .," it would be advantageous to have observed the student for at least one month prior to using the BES. However, if concerns develop relative to serious behavior problems which require evaluation as soon as possible at the beginning of a school year, the observation period can be reduced. Information provided by the rater concerning length of the observation period should, of course, be considered when interpreting results from the BES.

Using the Ratings with Items

The definition of behavior disorders/emotional disturbance states that the designated characteristics must occur ". . . to a marked degree. . .," which may be considered to refer to both frequency and severity of behaviors. The subjectivity of the procedures used to measure behavioral frequency in many existing behavior rating scales has limited their usefulness (McLoughlin & Lewis, 1981). Descriptions of behavioral frequency such as "occasionally" or "frequently" certainly do not reflect precise educational assessment. To eliminate subjective judgments which are made when such descriptors are used, the BES provides ratings based upon the following quantifiable frequency ranges:

1 . . . NEVER OR NOT OBSERVED
2 . . . LESS THAN ONCE A MONTH
3 . . . APPROXIMATELY ONCE A MONTH
4 . . . APPROXIMATELY ONCE A WEEK
5 . . . MORE THAN ONCE A WEEK
6 . . . DAILY AT VARIOUS TIMES
7 . . . CONTINUOUSLY THROUGHOUT THE DAY

Raters should select the rating which most accurately describes the frequency of occurrence of each behavior on the scale. These ratings were developed to provide the rater with specific frequency descriptors which do not necessitate actual direct and continuous observation and recording of frequency data for each individual behavior. (The supplemental BES Data Collection Form is recommended for use when direct and continuous measurement procedures are desired).

Additional Instructions for Use at the Secondary Level

Secondary level teachers or other specialized area personnel completing the scale may not have the student in a self-contained program for an entire day. In this situation, the rater still selects the appropriate rating to most accurately describe the student's behavior during the period of time the student is in the program each week. Since the rater indicates the amount of time spent with the student each week, interpretation of ratings can be made relative to actual observation periods. It is appropriate and even desirable to have more than one teacher complete the BES for a secondary level student.

SCORING, INTERPRETATION AND USE OF THE BES

Weighted Scores for Individual Items

Each item on the scale is weighted (1, 2, or 3) according to the relative severity of the respective behaviors. The weighted score for each item is easily computed by multiplying the assigned rating by the weighting factor. Weighted scores for individual items, therefore, reflect both the frequency and severity of behaviors.

Subscale Raw Scores

The raw score for each of the five subscales is computed by adding the weighted scores for the items within the subscale. Subscale raw scores have limited usefulness and should not be used to make decisions based upon an individual sutdent's performance on the BES. Since the five subscales on the BES contain differing numbers of items, subscale raw scores cannot be meaningfully compared to one another.

Subscale Standard Scores

Raw scores are converted to standard scores for the purpose of establishing a clear and consistent basis for making comparisons among students who are evaluated. Standard scores from 7 through 13 on the BES are considered to be "normal", or statistically average or typical, while standard scores greater than 13 and less than 7 are considered to be statistically deviant or atypical. Specifically, scores greater than 13 indicate that the student exhibits few, if any, behaviors of concern on the subscale, while scores from 7 through 13 indicate that the student's behavior is similar to the behavior of the majority of students included in the normative sample on whom the scale was standardized. Scores less than 7 indicate that the student, as rated by the individual using the scale, exhibits negative or inappropriate behaviors frequently enough to cause concern. The degree of concern generally increases as standard scores decrease, with scores less than 4 representing extreme statistical deviance. Subscale standard scores from the BES may be compared with one another since they share a common scale of measurement. Such comparisons may reveal areas of behavioral strengths and deficits.

Behavior Quotient

This composite standard score is computed by adding the standard scores from the five subscales and converting the sum to the Behavior Quotient. The Behavior Quotient represents a global index of a student's behavior in all of the areas measured within the total scale. The quotient is designed to have a mean of 100 with a standard deviation of 15.

Behavior Quotients from 85 through 115 are considered to be "normal", or statistically average or typical, while Behavior Quotients less than 85 and greater than 115 are considered to be statistically deviant or atypical. The degree of concern generally increases as the Behavior Quotient decreases, with scores less than 70 representing extreme statistical deviance.

Cautions in Interpreting Scores

No single test, criterion, or formula exists which can simply and reliably yield diagnostic decisions pertaining to eligibility for placement in special education programs. It must be emphasized that scores based upon normative data, whether derived nationally or locally, only indicate the relative status of an individual student's performance in comparison with the performance of other students on whom the test was standardized. Accordingly, school personnel cannot make decisions regarding eligibility, placement, or programming for a student based only upon obtained BES results. Additional information relating to several areas of functioning, including the social/emotional or behavioral area, must be gathered from a variety of sources before appropriate decisions can be made.

Development and Use of Local Norms

The heterogeneity and complexity of behavior problems would seem to preclude the existence of a single norm or standard of behavior for districts of varying geographical location and size across the nation. Indeed, even within a given community, behavioral expectations and problems within one district may significantly differ from those found within another district. Certainly differences in behavioral standards and problems may be quite pronounced when comparing large, metropolitan districts to small, rural districts. While nationally-derived norms may or may not be representative, and accordingly, useful, within an individual district, prevailing local standards of behavior must be considered when making educational decisions regarding eligibility, placement, and programming.

To avoid or minimize the possibility of using normative data that may not be appropriate within a particular district or program, several authors have recommended that local norms be established for comparative purposes (Elliott & Bretzing, 1980; Reid & Hresko, 1981; Lyman, 1978; Wallace & Larsen, 1978). These local norms are not to be used necessarily in place of national norms unless the existing national norms clearly do not reflect the local population. Instead, local norms can be developed in many cases to complement published national norms. Indeed, it is desirable to derive local norms simply to verify the applicability of national data that are provided with tests. Additional information regarding the development and use of local norms with the BES may be obtained by contacting the authors through Educational Services, P.O. Box 1835, Columbia, Missouri 65205.

Using the Student Record Form

The steps involved in using the Student Record Form are as follows:

1. The teacher or other school personnel rating the student should review the "Guidelines for Using the BES" provided on the Student Record Form.

2. All background information at the top of the first page of the Student Record Form should be completed.

3. Ratings are assigned to the items included in the "Items" section of the Student Record Form in accordance with the instructions for administering the BES.

4. Ratings from each of the items are transferred from the scale to the designated spaces (identified by item numbers) in the Ratings column on the "Data Summary Sheet." The Student Record Form has been constructed to permit easy transfer of ratings from the scale to the "Data Summary Sheet" by simply opening the form to expose all three pages simultaneously.

5. Each rating is multiplied by the designated weighting for each item and the resulting numbers are recorded in the Weighted Score column on the "Data Summary Sheet."

6. The sum of the weighted scores for items is computed for each of the five subscales. These numbers are recorded in the space designated as Raw Score for each subscale on the right side of the "Data Summary Sheet."

7. The subscale raw scores are converted to standard scores and recorded in the boxes referred to as Standard Score for each subscale on the "Data Summary Sheet."

8. The sum of the five subscale standard scores should be computed and recorded at the bottom of the "Data Summary Sheet" in the space designated as Sum of Subscale Standard Scores.

9. The sum of the five subscale standard scores is converted to a Behavior Quotient and recorded at the bottom of the "Data Summary Sheet" in the box designated as Behavior Quotient.

10. The subscale standard scores and the Behavior Quotient can be transferred to the "BES Profile" which appears at the bottom of the first page of the Student Record Form. This profile is particularly useful for graphically representing a student's behavioral functioning to other school personnel and to parents. The shaded area at the bottom of the "BES Profile" indicates probable areas of concern within the behavioral or social/ emotional area.

11. The "Comments" page should be used to record additional observations and information which may be helpful to consider when interpreting results from the BES. It will be especially beneficial for the rater to provide additional information (e.g., antecedents and consequences of behavior, more detailed descriptions of behavior, etc.) for those behaviors which are of greatest concern based upon the relative size of the weighted scores of items and based upon the rater's perceptions.

Figures 2 and 3 contain examples of the "Data Summary Sheet" and the "BES Profile" which have been completed for a student in accordance with the procedures described above.

Insert Figure 2

Insert Figure 3

Behavior Evaluation Scale

Stephen B. McCarney, Ed.D.
James E. Leigh, Ph.D.
Jane Cornbleet, M.Ed.

STUDENT RECORD FORM

Name of Student: Richard S. Ethnic Origin: Caucasian Sex: M
Class: — School: Lincoln Grade: 5
City: Trenton State: Ohio Rated by (Observer's name): Mrs. Trout

Date of Rating	82 (year)	10 (month)	20 (day)
Date of Birth	72 (year)	5 (month)	20 (day)
Age at Rating	10 (years)	5 (months)	

Dates during which student participated in your class: From 8/25 To 10/20
Length of time spent with student: Per day 6 hours Per week 30 hours

BES PROFILE

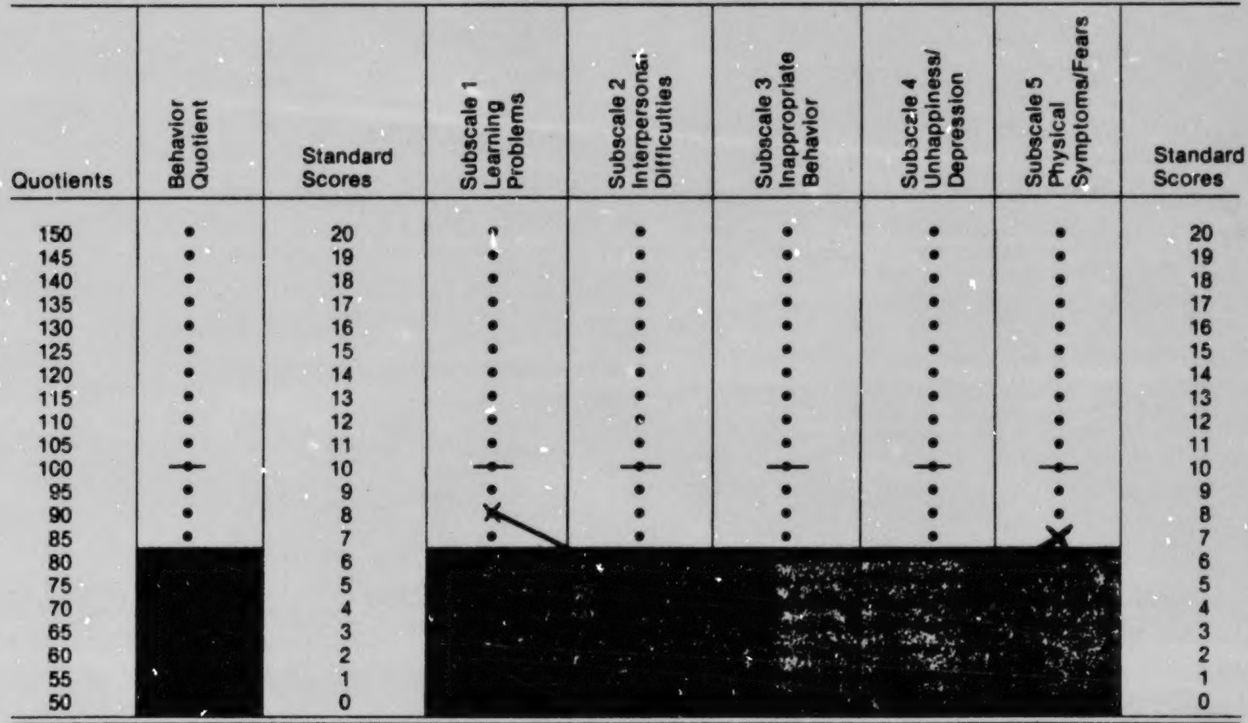

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Figure 2.
Sample BES Profile

DATA SUMMARY SHEET

Characteristic	Ratings		Weighting		Weighted Score	Raw Score	Standard Score	
1. An inability to learn which cannot be explained by intellectual, sensory, or health factors.	4. 2	×	2	=	4	44	8	Subscale 1
	11. 6	×	2	=	12			
	19. 2	×	1	=	2			
	27. 2	×	2	=	4			
	35. 2	×	2	=	4			
	42. 6	×	1	=	6			
	45. 6	×	2	=	12			
2. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.	1. 1	×	2	=	2	76	5	Subscale 2
	3. 6	×	3	=	18			
	9. 6	×	3	=	18			
	17. 5	×	2	=	10			
	25. 4	×	2	=	8			
	33. 1	×	2	=	2			
	40. 1	×	1	=	1			
	44. 1	×	3	=	3			
	46. 6	×	2	=	12			
	48. 1	×	2	=	2			
3. Inappropriate types of behavior or feelings under normal circumstances.	2. 3	×	2	=	6	164	4	Subscale 3
	5. 6	×	2	=	12			
	7. 6	×	1	=	6			
	10. 4	×	2	=	8			
	14. 3	×	3	=	9			
	16. 4	×	2	=	8			
	18. 3	×	2	=	6			
	20. 2	×	3	=	6			
	22. 6	×	2	=	12			
	24. 6	×	3	=	18			
	26. 3	×	3	=	9			
	28. 2	×	1	=	2			
	30. 5	×	2	=	10			
	32. 6	×	3	=	18			
	34. 3	×	1	=	3			
	36. 2	×	3	=	6			
	38. 2	×	2	=	4			
	41. 6	×	3	=	18			
	50. 1	×	3	=	3			
4. A general pervasive mood of unhappiness or depression.	6. 2	×	1	=	2	43	4	Subscale 4
	13. 6	×	1	=	6			
	21. 6	×	2	=	12			
	29. 1	×	1	=	1			
	37. 1	×	2	=	2			
	51. 5	×	2	=	10			
	52. 5	×	2	=	10			
5. A tendency to develop physical symptoms or fears associated with personal or school problems.	8. 4	×	1	=	4	30	7	Subscale 5
	12. 1	×	3	=	3			
	15. 4	×	2	=	8			
	23. 3	×	2	=	6			
	31. 1	×	2	=	2			
	39. 1	×	2	=	2			
	43. 1	×	2	=	2			
	47. 1	×	2	=	2			
	49. 1	×	1	=	1			

Sum of Subscale Standard Scores 28

Behavior Quotient 69

Figure 3.
Sample Data Summary Sheet

Using BES Results

Three levels of analysis are possible when interpreting results from the BES: total score analysis, subscale profile analysis, and item analysis. It is essential that school personnel become familiar with the characteristics of each of the types of scores discussed earlier before attempting to interpret results from the scale.

Total Score Analysis

This level of analysis represents the broadest, and perhaps least useful, level of interpretation of BES results. The Behavior Quotient is based upon performance on all items across all five subscales, and thus does not reveal specific behavioral strengths or concerns. Inferences at this level may only be made regarding a student's over-all comparative status in the behavioral domain in general. Under no circumstances should school personnel use the composite Behavior Quotient as the sole criterion to diagnose a student as "behaviorally disordered" or "emotionally disturbed."

Subscale Profile Analysis

The BES subscales were developed on the basis of the five characteristics of behavior disorders/emotional disturbance included in the most widely used definition in the field. The subscale standard scores indicate whether a student's behavior is "average" or atypical relative to each characteristic based upon statistical normative data. School personnel are reminded that the definition stipulates that the condition of behavior disorders/emotional disturbance may be manifested in "one or more" of the five characteristics. Therefore, subscale performance on the BES provides an important source of information to consider when determining whether a student is eligible to receive services in a program designed for "behaviorally disordered" or "emotionally disturbed" students. Again, additional information must be gathered before a final diagnostic determination is possible.

Subscale profile analysis using the BES is also highly useful for documenting behavioral areas of strength and concern for all referred students, regardless of which handicapping conditions may or may not be present. Students with learning disabilities, mental retardation, physical handicaps, sensory deficits, and other impairments will frequently exhibit problems in one or more of the five behavioral areas measured within the BES.

Item Analysis

School personnel will derive particular benefit from examining ratings for individual items on the scale. Such analysis contributes essential information for making decisions relative to programming and intervention. School personnel who field-tested the BES reported that broad annual goals for students could be determined from performance on the five subscales, while specific instructional objectives were easily derived from performance on specific items within the subscales.

Individual items on the BES, when considered in isolation, certainly are not indicative of behavior disorders or problems. However, when an individual behavior occurs to a significant extent over a long period of time in conjunction with other behaviors on the scale, and when the resulting behavioral patterns "adversely affect" educational performance, sufficient reason for concern may exist.

All behaviors referred to within BES items are not equal in significance. Therefore, interpretation of BES results should involve consideration

It would even be possible, though unlikely, for a student to obtain average standard scores on each of the five subscales, yet exhibit one or two quite serious behaviors which would require special services through a program in behavior disorders/emotional disturbance. The weighted scores are designed to account for such differences in severity among behaviors. However, to avoid misinterpretation of BES results based upon obtained scores, the rater should circle the item numbers of behaviors of greatest concern when completing the scale. School personnel can then give special consideration to the significance or severity of those behaviors when making decisions.

Additional Suggestions for Using BES Results

The period of time during which the student has been observed should be considered when analyzing BES scores at any level. The length of time becomes especially significant at the secondary level in which teachers may have a student for only part of the school day. As indicated, it is advisable for more than one teacher at the secondary level to evaluate a student when possible.

BES results should always be interpreted in conjunction with all other information obtained for a student. Additional information provided by teachers concerning antecedents and consequences of behaviors of concern would be extremely useful. Similarly, information obtained from other behavioral assessment procedures certainly would be beneficial for corroborating or complementing results obtained from the BES.

NOTE: The authors would appreciate receiving any suggestions, comments, or data resulting from the use of the Behavior Evaluation Scale by school personnel or researchers.

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CLINICAL AND EDUCATIONAL PERSPECTIVES ON LANGUAGE INTERVENTION FOR CHILDREN WITH AUTISM

Alan G. Kamhi, Lauren K. Nelson, and Lacy H. Wray

BASES OF LANGUAGE INTERVENTION

Perspectives on the Etiology of Autism

The perspective one takes concerning language intervention with the severely emotionally disturbed and autistic depends in large part on the way in which one views the causal bases or etiology of the disorder. In our presentation today, we will consider some of the perspectives that have been used to view autism. We chose to narrow our discussion to the autistic population because the clinical research involving these children is extensive and the difficulties these children present for language intervention are representative of the ones that other severely emotionally disturbed children would present.

Early theories on the etiology of autism saw the disorder as having a psychogenic base which derived from a deviant environment rather than a congenital cognitive or psychosocial disorder. Representative of these theories is Kanner's (Kanner & Eisenberg, 1955) view that the disorder was partially due to lack of affection from the parents -- a psychogenic disorder due to "emotional refrigeration." In the same vein, Bettleheim (1967) considered autism to be a reaction to pathological parental behavior, usually involving the mother. Finally, principles of learning theory and operant conditioning have also been used to explain autism. Ferster (1961) suggested that parents of autistic children have inadvertently reinforced deviant behaviors while failing to reinforce appropriate ones.

In recent years, perspectives on the etiology of autism have stressed the organic bases of the disorder, much to the relief of parents of these children who previously had to suffer the blame for their child's behavioral abnormalities. It is now known (e.g., Rutter, 1979) that autistic behaviors can develop from a number of diverse neuropathological conditions, including phenylketonuria, congenital rubella, tuberous sclerosis, lead intoxication, and congential syphillis. In a recent review of the relevant literature, Morgan (in press) concludes that it is doubtful that "autism represents any single disease entity or results from any single etiological factor." Consistent with this conclusion, McLean and Snyder-McLean (1978) suggest that there are probably many different and distinct syndromes of autism and these different syndromes are associated with different etiologies.

This change in perspective from "external source theories" to "internal source theories" has led to research which has attempted to delimit the cognitive, linguistic, and social abilities of these children. This research indicates that most autistic children suffer from cognitive, linguistic, and social/motivational deficits. Recently, some investigators (Churchill, 1978; Ricks & Wing, 1975; Rutter, 1979) have concluded that autism represents a severe and pervasive impairment of the higher cognitive functions of symbolic thought and language. Churchill (1978) has gone so far as to argue that language deficits represent the necessary and sufficient cause of those symptoms common to all autistic children. Though the cognitive and linguistic impairment is certainly a central component of the syndrome of autism, these aspects should not be emphasized to the point where the social/motivational deficit is overlooked.

The change in perspective from external to internal source theories has also had a profound impact on the way in which these children's behavioral disorders are assessed and treated. Because the language deficit was now thought to play a central role in the disorder, language specialists necessarily have become a crucial member of the team of professionals involved in habilitating autistic children. In fact, many now believe that circumventing the communication handicap is the single most important task facing parents and educators who work with autistic children (NSAC Advocate, 1980). DeMyer (1979), based on her clinical experiences with 155 autistic children and their families, found that communication problems were uppermost in the minds of parents and it was to help improve their children's communication that they came to seek professional help.

Unfortunately, recognizing the centrality of the language and cognitive deficits in autistic children has been somewhat easier than deciding what to do about these deficits. Prizant (1982) argues that a major problem in the planning of educational and communication programs for autistic children is that individuals who are not very familiar with language and communication processes are often responsible for planning these programs. Lovaas' (1977) work epitomizes this lack of knowledge, as he attempts to justify his operant approach to language training by stating that "there is a great deal which we do not know as yet about language learning" (p. 4). As Prizant (1982) points out, Lovaas has failed to incorporate into his program what we have learned about language learning and intervention over the past two decades.

In order to develop and implement effective language intervention programs with autistic children, it is necessary to know what language is, how it develops, what factors underlie its development, and how deficits in one or more of these factors (structures/processes) can lead to breakdowns in language. Because speech-language pathologists have received extensive training in these areas, they need to play a major role in assessing and planning strategies for the habilitation of autistic children. Nevertheless, the speech-language pathologist is usually just one member of a team of professionals responsible for the habilitation of these children. The fact that the language deficit is a central component of autism suggests that all who work with the autistic should have some familiarity with language and language-learning processes.

What is Language?

In the remaining time, I would like to address some of these points, beginning with the question, "What is language?" The question is not an easy one to answer because language can take many forms (acoustic, phonetic, syntactic, etc.), express a variety of contents (i.e., different concepts), and serve numerous different functions, not all of which are communicative. Given the complexity of language, it has proven useful to divide language into four domains: phonology, syntax, semantics, and pragmatics. In order to understand and produce language, children must eventually internalize specific rules in each of these four language domains. The process of language development can be thought of as a gradual internalization of these rules of language (phonology, semantics, and syntax) and communication (pragmatics). Briefly, the rules of phonology describe how to put sounds together to form words; the rules of syntax describe how to put words together to form sentences and how to use grammatical markers to indicate tense, aspect, possession and other modulations of meaning; the rules of semantics indicate which words express which concepts and which words can combine with other words; and the rules of pragmatics indicate how to participate in a conversation (i.e., rules for turntaking, making presuppositions, ordering topics, and so forth).

Perception and Comprehension of Language

It has also proven useful to differentiate among the processes of perception, comprehension, and production of language. Figure 1 presents a model of the perception and comprehension of speech and language. In order to understand why a child might not be understanding language, it is important to understand the various places or points where the processing of a message may break down. Let us briefly consider what is involved in perceiving and

Perception and Comprehension of Speech and Language
A Process Model

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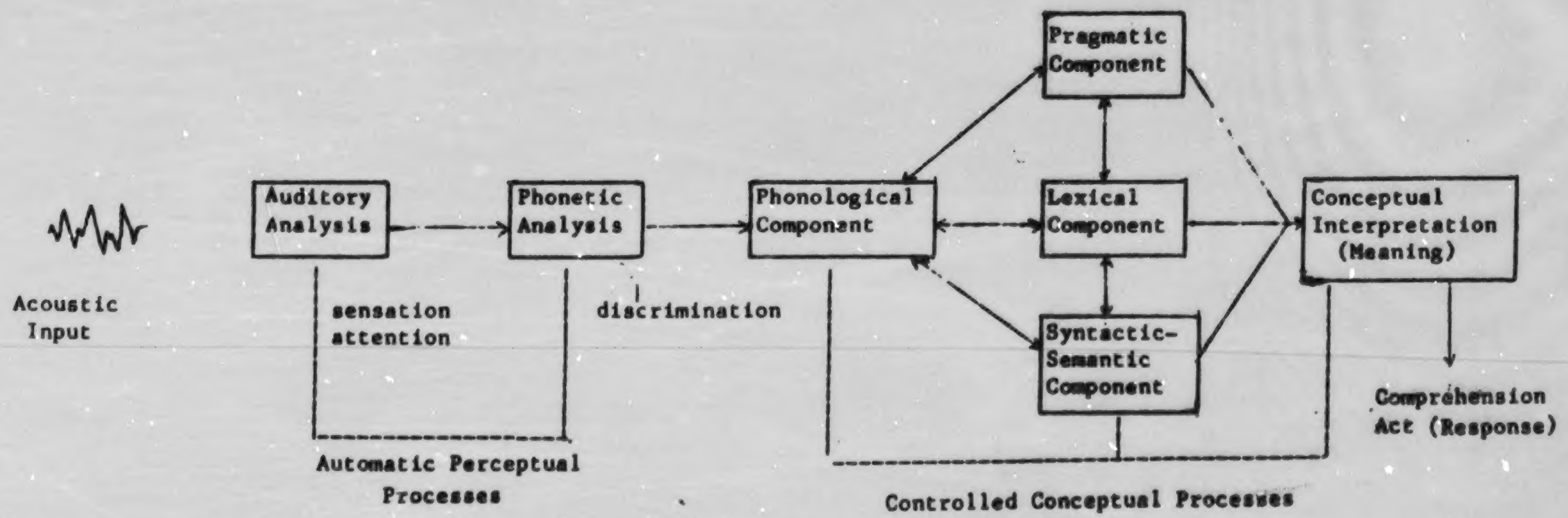
Pragmatic Component
Auditory Analysis
Phonetic Analysis
Phonological Component
Lexical Component
Conceptual Interpretation (Meaning)
Acoustic Input
sensation
attention
discrimination
Syntactic-Semantic Component
Comprehension Act (Response)
Automatic Perceptual Processes
Controlled Conceptual Processes

Figure 1

comprehending speech and language. Note that the first box is entitled, "Auditory Analysis." In order to analyze the sounds that make up the speech stream, one has to be able to hear these sounds (sensation) and devote some minimal attention to them. A deaf child will necessarily have difficulty understanding spoken language, whereas a child who does not attend to speech, as many autistic children do not, will also have difficulty understanding speech.

Presuming that some sensory ability is present and the child has attended to the message, the next step is to segment the auditory input into phonetic units. To do this, the individual must be able to discriminate among these phonetic units, a perceptual ability that is influenced by maturational and environmental factors. A deficient environment or delayed maturation of the mechanisms involved in discrimination will lead to problems at this stage. These first two stages are often called, "low-level speech perceptual processes" because they are highly automatic; that is, the sensation and discrimination of speech often occurs below the level of conscious awareness. These low-level stages can be contrasted with the so-called "higher-level" stages of speech perception and comprehension. In these stages, knowledge of the language and knowledge of the world are used to assign meaning to phonetic representations.

Higher-level processes have been shown to play an important role in the perception and comprehension of speech and language. In fact, much of our comprehension of language is thought to occur in what is called "top-down" fashion, whereby listeners use their knowledge of language and the communicative situation to assign meaning to speech.

To illustrate what is meant by a top-down comprehension process, try to reconstruct the last sentence I said. Can you remember more than one or two words in the sentence? Note how little information you remember about the sounds in the sentence or even the syntactic structure of the sentence. Imagine how difficult it would be, if in order to understand language, you had to process speech from the bottom up, paying attention to sounds, words, syntactic, structures and so forth. Bottom-up processing is not only difficult but it is also inefficient. Yet many language disordered children process speech in this way because they do not know the language or rules of communication well enough to develop top-down processing strategies.

Children with behavioral and social-interactive problems, such as the autistic, have particular difficulty understanding speech because they do not take advantage of situational and contextual factors to aid them in comprehension. Their poor social-interactive skills usually make them unresponsive to communicative behaviors that help to make the association between the speech signal and its referent more salient (e.g., mutal referencing behaviors, such as pointing). The result is that in order to comprehend speech, many autistic children must rely primarily on the information in the speech signal. The fact that many of these children also suffer from cognitive deficits serves to compound the problem that these children have understanding language. One can imagine many of these children tuning out speech and withdrawing further into themselves in reaction to their inability to understand speech. Moreover, even if an autistic child had the necessary cognitive and attentional skills to comprehend speech, a lack of motivation to respond or a lack of knowledge how to respond might cause the child not to acknowledge that he understood what was said.

Production of Speech-Language

Given the frequency of echolalic responses in the speech of autistic children, it is also important to have some familiarity with the stages and components in the speech production process. The first stage involves the formulation of the message content, i.e., the idea, or proposition to be talked about. Once the message has been formulated, the next step is to plan the type of discourse to be used according to the types of listeners involved, the situational context, and the intent of the communicative act. Once this is done, then one must retrieve the words to be used in the sentence and assign the appropriate phonologic, syntactic, and semantic structure to these words. The "sentence plan" which now contains all the relevant phonological, lexical, syntactic, and semantic information, is then transmitted to the articulators. The final step is to produce or execute the sentence plan. It should be apparent that, like comprehension, speech production is a complex series of events and, more importantly, that difficulties in speech production can be caused by any number of factors. With regard to autistic children, it is generally found (e.g., Baltaxe & Simmons, 1981) that they encounter the most difficulty in the first two stages in the speech production process: formulating messages and taking pragmatic factors into account. They seem to have little difficulty actually articulating the sentence plan.

Bases of Language

The knowledge that language consists of different domains that, in turn, have receptive and productive aspects enables one to appreciate the diversity that exists in the types of language disorders that children can present. Recent studies involving autistic children (Baltaxe & Simmons, 1981; Prizant, 1982) have in fact documented considerable variability in these children's language performance. In addition to being able to describe accurately the different levels of language performance of these children, one must also have some knowledge of the forces that influence the perception, comprehension, and production processes involved in language and language development.

Language performance is influenced by four forces: 1) biological forces, 2) cognitive forces, 3) psychosocial forces, and 4) environmental forces. These forces interact in complex ways in the language acquisition process. Moreover, the way in which these forces interact in a particular child determines the types of language behaviors or deficits this child will present. Thus, not only must one be able to describe the language behaviors of individual autistic children, but one must also have procedures to evaluate the influence of biologic, cognitive, psychosocial, and environmental forces in each child's development.

Summary

I have spent some time outlining the areas that should be evaluated in the assessment of autistic children's language abilities. Effective language intervention depends, in part, on the ability of the interventionist to determine a child's level of functioning in these areas. For example, one must decide if the child is cognitively and socially ready to use a representational system for communication. Some children might be functioning at such a low level cognitively that to teach language would more than likely cause only frustration and failure. Other children might not possess the social-interactive skills or motivation to interact necessary for communication to occur. Language training which merely requires verbal responses in highly structured contrived situations will meet with little success for children who show severe cognitive or social delays. For some of these children, it might be better to begin with a nonverbal system of communication.

In the next part of our presentation, Lauren will discuss in more detail some current approaches to language intervention with the autistic and present some specific suggestions for intervention using a few clinical examples.

COMPARISON OF TRADITIONAL AND COMMUNICATIONS BASED INTERVENTION PROGRAMS

Traditionally, language intervention programs have employed behavior modification procedures and have focused on the establishment of verbal responses through sound, word, and sentence imitation. Such programs, when used with autistic children, have been successful in some respects and dismal failures in other respects. In general, traditional behavioral programs have been able to establish verbal imitation, labeling, use of grammatically correct sentences, and limited conversational skills. However, these gains in linguistic skills have not been maintained after removal of external reinforcement, nor have they been generalized to situations outside the immediate training environment. Autistic children, in particular, tend to respond to irrelevant properties of the training stimuli and to develop verbal behaviors which are restricted to the specific training situation (Lovaas, 1977). In the following presentation, I will suggest that the limitations of traditional behavioral intervention programs are due to (1) a failure to consider the cognitive and social-motivational bases of language and (2) a failure to distinguish among speech, language, and communicative skills. Further, I will suggest that an intervention program which teaches language in context - a context that includes the cognitive and social bases as well as communicative functions of language - can circumvent some of the problems of traditional behavioral approaches.

As previously noted, one reason for the limited success of traditional language intervention programs may be a failure to recognize the distinction among speech, language, and communication. The use of speech does not necessarily entail the use of language or the occurrence of communication. The occurrence of communication does not necessarily entail the use of language or speech. Communication is the more general term and is used to refer to the intentional transmission of information from one individual to another (Ricks & Wing, 1976). Communication may be accomplished verbally through spoken language, written language, or sign language, or non-verbally through gesture, facial expression, eye contact, or body posture. Language refers to the use of arbitrary symbols to represent concepts or ideas. These symbols occur in systematic relationship to each other as specified by the rules of grammar. The symbols used in language may be spoken, written, manual signs, or other arbitrary symbol systems.

Autistic children not only have difficulty learning to use words to refer to concepts and ideas and to combine words in sentences, they also have difficulty learning to communicate with words. One mother described the communicative problems of her child in the following passage from the book The Siege (Park, 1982, p. 74).

> There was another peculiarity of her language that went far beyond its sparseness. Elly spoke words, though not often. But she did not use them to communicate. She had no idea of language as a tool that could cause things to happen. By the time she was two and a half, there were several more words to add to the record. A few were simple nouns like "book," "pin," and "milk." Others were sounds referring to activities, like the "there she is!" intonation with which she responded to the peekaboo game in which I had finally succeeded in interesting her. But not one of these words was ever *used*, as distinguished from merely spoken. If Elly saw me, she might or might not say "mama." She would never use the name to call me. She might possibly say "teddy" if he appeared. She would never ask for him by name.

Traditional intervention programs have focused on developing a repertoire of verbal responses while ignoring the communicative problems of autistic children. This could be one reason for the limited success of traditional approaches. Children have no reason to maintain or generalize verbal responses which serve no communicative purpose.

Another possible reason for the limited success of traditional approaches is a failure to consider the social-motivational and cognitive bases of language in designing intervention programs. The social-motivational and cognitive bases of language are closely related to the use of language as a tool for communication. Baltaxe and Simmons (1981, p. 304) suggested that pragmatic or communicative competence "can be understood as the interface between social, cognitive, and linguistic development." It follows that problems with communication may be related to general cognitive and social deficits.

Autistic children's inability to use speech and language for purposeful communication, as a means to some end, may reflect a general deficit in goal-directed or means-end behavior (Schuler, 1980). If an autistic child does not use direct action to manipulate the environment or to accomplish specific goals, then he or she is unlikely to use language as a means to manipulate the environment. Autistic children's failure to use language in interacting with other persons may reflect a general deficit in social-interactional skills. If an autistic child has no need or desire to interact with other persons, and does not do so non-verbally, then he or she has no reason to learn language as a tool for communicating with others. In order to develop language as a means for communication, language that will be generalized and maintained, language intervention programs may first have to address the basic deficits in intentional behaviors and social-interactional skills.

A Communication-Based Approach

We propose a communication-based approach which encompasses the communicative functions as well as cognitive and social bases of language as an alternative to traditional language intervention programs. This program corrects the weaknesses of traditional intervention programs while maintaining those elements, such as the use of systematic, structured training procedures and clear-cut reinforcing consequences, which have proved beneficial. The basic promises of the communication-based approach are the following:

1. Structured training procedures are necessary for the development of language and communicative skills in autistic children; however, structured training can and should be provided within the context of the child's usual daily activities.
2. Clear-cut reinforcing consequences are desirable, but these consequences should be related naturally rather than artifically to the child's responses.
3. Communicative skills, rather than speech and language skills, should be the primary focus of intervention. When necessary the use of nonvocal or limited communication systems should be considered.
4. The cognitive and social-motivational bases of language and communication should be considered in selecting goals for intervention. In some instances it may be desirable to train prerequisite cognitive and social skills before beginning a language intervention program.

If a child does not learn language in its natural context, then more direct and structured training procedures are appropriate. However, the use of structured training procedures does not imply that communication skills should be taught in a highly controlled situation outside of the child's normal environment. Since autistic children tend to associate newly acquired skills with the initial learning situation, these situations must be as natural as possible. Training should be provided in the context of the child's usual play, feeding, and work activities. Similarly, the issue is not whether clear-cut reinforcing consequences should be provided, but what the nature of these consequences should be. If a child says "car," should he or she receive a raisin for correctly labeling a picture, or should he or she receive a toy car to play with? In the first case, reinforcing consequences are artificially associated with the response, whereas in the second case the reinforcing consequence is a natural outcome of the child's use of language.

While the training environment and nature of reinforcing consequences may be somewhat different in the communication-based approach, the most significant differences are related to the goals of intervention. Traditional approaches focus on the development of a repertoire of verbal responses through sound, word, and sentence imitation. In contrast, the communication-based approach focuses on the development of communicative skills and on the development of cognitive and social skills which may be prerequisites for the development of language and communication. This is an important difference which reflects a recognition of the complex interaction among cognitive, social, and linguistic knowledge in the development of language and communication skills.

A communication-based approach to the development of communicative skills has several important implications for the design of intervention programs. First, the focus on developing communicative skills rather than on speech and language skills is consistent with the use of alternative communication systems. Communicative skills may be established more rapidly by employing responses already within a child's behavioral repertoire. Developing complex vocal responses may require extensive training which might overly frustrate the autistic child. Second, rather than teach only the referential functions of language (e.g. labeling objects), other more communicative functions of language can be taught (e.g. directing others' behavior, requesting objects, or expressing intentions). Finally, not all children have the necessary social or cognitive prerequisites for learning language. Attempting to teach these children speech and language skills will prove unsuccessful at best and probably will be frustrating for the child and teacher. However, if the focus of training is on communication and its social-cognitive prerequisites, then there are at least two other options: 1) teaching a more limited communication system that enables the child to communicate basic needs and desires, or 2) teaching the necessary prerequisite social interactional and goal-directed behaviors. Because the communication-based approach encompasses the communicative functions as well as cognitive and social bases of language, clinicians and teachers using this approach have greater flexibility in meeting the needs of individual children.

The general premise of a communication-based approach to the development of language and communicative skills in autistic children has been discussed in the previous section. In the next part of this presentation, differences between traditional approaches and the communication-based approach will be illustrated by comparing intervention goals for different autistic children.

Intervention Goals

One of the difficulties in designing intervention programs for autistic children is that autistic children do not represent a homogeneous group. Some autistic children are nonverbal, others are limited to single words or imitative speech, while still others are able to produce sentences but have difficulties with interpersonal communication. Therefore, in this presentation we will consider how intervention procedures might vary based on the cognitive, social, and language abilities of these children. In the time remaining I will provide some specific suggestions for language intervention with different autistic children.

Nonverbal Autistic Children

The group of nonverbal children includes children who seldom or never vocalize and children whose vocalizations are nonmeaningful. Traditional language intervention programs usually attempt to teach these children to imitate speech sounds and words. The general goals for nonverbal children from a traditional perspective are summarized below.

Goals for Nonverbal Children - Traditional Approach

1. Increase the occurrence of spontaneous vocalizations through reinforcement.
2. Develop nonverbal imitation skills through shaping, prompting, and reinforcement.
3. Develop verbal imitation skills after nonverbal imitation is established through similar procedures.

As illustrated by these general goals, traditional intervention programs emphasize speech development with nonverbal children. In contrast, the communication-based approach emphasizes the development of communicative skills, verbal or nonverbal, and the development of prerequisite social and cognitive behaviors. Several general goals for nonverbal children from a communication-based perspective illustrate this emphasis.

Goals for Nonverbal Children - Communication-Based Approach

1. Develop intentional, goal-directed behaviors such as grasping or reaching for objects, approaching other people or objects, and vocalizing to get attention.
2. Develop the use of a pointing or indicating gesture as a means for communicating wants or needs.
3. Develop symbolic play skills with meaningful objects such as dishes, dolls, doll furniture, and toy cars.
4. Develop social-interactive skills such as a means for initiating interaction (showing a toy, touching, or approaching), and responses to the initiations of others (eye contact, or turn-taking).
5. Consider the use of a nonvocal system of communication if the child does not vocalize spontaneously or does not attend to the speech of others.

The general goals listed above provide greater flexibility in designing an intervention program for individual children and address the problems that autistic children have with social interaction, means-end behavior, and the use of gestures (Ricks and Wing, 1976; Prizant, 1982).

Echolalic Children

Echolalic children include those children whose speech is generally limited to the meaningless repetition of words or groups of words just spoken by another person. The traditional and communication-based approaches to these children reflect two different views of echolalia. The traditional view is that echolalia is an abnormal behavior which should be eliminated and replaced by more appropriate linguistic behaviors. The second view is that echolalia may represent a different language acquisition strategy, may serve different functions for the autistic child, and should be exploited in therapy programs rather than eliminated.

The goal of traditional language intervention programs is to teach the child when it is appropriate to imitate and when it is not appropriate to imitate. In the context of such a program the child is taught to imitate only the verbal prompts presented during training. Imitation during spontaneous interactions would be inappropriate (Lovaas, 1977).

Prizant and Duchan (1981) suggest that it may be a mistake to eliminate echolalia in spontaneous interactions since echolalia can serve a number of different functions for autistic children. Echolalia may be a means for social interaction or turn taking, for self-regulation, for answering, and for requesting. Rather than eliminate echolalia, these authors suggest that the goal should be to modify and expand the child's echolalic utterances and to incorporate them into functional communicative contexts. One way to accomplish this is to use two adults in a training session. One adult serves as an interlocutor who converses with the child and the other serves as a prompter who provides appropriate responses for the child to imitate (Philips & Dyer, 1977).

Single-Word Stage

The intervention goals for the traditional and communication-based approaches to language intervention also differ for children who are using single words. The general goal of the traditional approach is to establish a basic vocabulary of nouns and verbs (Lovaas, 1977). More specific goals are presented below.

Goals for the One-Word Stage - Traditional Approach

1. Teach the child to identify objects and to perform actions in response to noun and verb labels.
2. Teach the child to use noun and verb labels to name objects and actions, and to respond to questions such as "What is that?" and "What are you doing?"
3. Teach the child to ask the question "What is it?" about objects in the environment.

The general goal of the communication-based approach for children in the one-word stage is to teach nouns and verbs as means for requesting objects and regulating actions. Further, this approach emphasizes conceptual skills and the need to develop basic categories of objects and actions to facilitate generalization of responses. Several general goals are presented below.

Goals for the One-Word Stage - Communication-Based Approach

1. Teach the child to use nouns and verbs to request objects and regulate actions.
2. Teach the child to ask the question "What is that?" to seek information about objects in the environment.
3. Teach the child to match perceptually similar and functionally similar objects as a means for developing categorization.

As illustrated above, both the traditional and the communication-based approach emphasize the importance of teaching children to seek information by asking questions. The major difference between the two approaches in the one-word stage is the emphasis on labeling in the traditional approach and the emphasis on functional communication in the communication-based approach. We must remember, however, that noun and verb labels are always spoken words in the traditional approach, whereas these labels may be manual signs or other arbitrary symbols in the communication-based approach.

Older Children and Adolescents

Even when autistic children reach the stage where they are using words in sentences, a number of language and communication problems still remain. Both the traditional and communication-based approaches to language intervention address the problems of older children and adolescents. The traditional approach focuses primarily on problems with sentence structure and use of grammatical markers to indicate tense, aspect, and possession among others, Conversational skills generally are not systematically dealt with. The communication-based approach also considers problems with sentence structure and grammar, but primarily focuses on problems with interpersonal communication. The general goals of the traditional approach are presented first.

Goals for Older Children - Traditional Approach

1. Teach the child basic word order rules to facilitate the use of words in sentences.
2. Teach the child the subtle "nuances" of grammar such as adjective-noun relationships, subject-verb relationships, and use of grammatical markers.
3. Teach the child to respond to simple social questions such as "How are you?" and "What's your name?"
4. Teach the child to ask simple questions such as "Is this a table? and "Is this a chair?" as a means to initiate conversation.
5. Teach the child to provide extended answers (spontaneity training) to questions such as "What did you have for breakfast?"

Of these general goals the most interesting training procedures are those associated with training conversational skills and spontaneity. The following conversation, taken from Lovaas (1977, p. 74) illustrates the training of conversational skills.

E Ricky, what's your name?
Ricky Ricky.
E That's right.
Ricky How are you feeling?
E No. Ask me what I asked you. Ricky! Say what's your name?
Ricky Ricky.
E No. Say, what's. . .
Ricky What's (pauses). . .
E Your. . .
Ricky Your (pauses). . .
E Say, name.
Ricky Name.
E Now, say it all together.
Ricky What's your name?
E Joan. Good boy, Ricky. That's good. That's good.

While the result of such training might be a superficially useful skill, this is precisely the kind of training situation which would be avoided in the communication-based approach. Normal speakers do not begin conversations with the same question every time, nor do they ask for information that is already known.

In spontaneity training children are taught to provide elaborated answers to simple questions. However, as with conversational training, the procedures used ignore basic elements of communication, such as the need to be informative and the need to provide relevant information. Another example from Lovaas (1977, p. 89) illustrates this point.

E What did you have for breakfast?
Scott Bacon and eggs, orange juice, and milk. Eggs are yellow, eggs are good. I like the eggs. The bacon is red and white, and I like the bacon.

> Milk is liquid, milk is good, and I like milk.
> Orange juice is good, O.J. is soft -- no! I
> had grapefruit. Grapefruit is good. I eat it
> with a grapefruit spoon, and that's all.

In providing this response the child used correct sentence structure, used different nouns, verbs, and adjectives, and used grammatical markers appropriately. However, any listener who received this reply to a question such as this would think that the child was a little weird. Since a listener would probably know the color of eggs and bacon and already know that milk is liquid, he or she would not expect or want to receive such an elaborate reply. Goals such as these may be particularly inappropriate for autistic children since they often provide listeners with more information than they care to receive about irrelevant topics (Schuler, 1980).

By emphasizing the importance of communicative skills the communication-based approach focuses on the most persistent problems of verbal autistic children. Even when these children have mastered complex linguistic structures, problems with social interaction and interpersonal communication remain as obstacles to a productive and independent life (Prizant, 1982). Two examples from Park (1982) illustrate the difficulties of one autistic adolescent with social interaction.

> Innocent and open, she would hug acquaintances too, regardless of gender, even, perhaps, strangers; she has had to be taught that she should smile and shake hands instead (p. 286).
>
> Another image: having retrieved her paycheck from the Friday mail, she is standing in line at the bank to deposit it. She is a little too close to the person in front of her, but she holds herself in check, trying not to push forward and succeeding. "Hello Jessy." They know her at the bank; they are nice to her, with the natural niceness of women who work in offices. They do not know much about her, but they know that she is different. A person is different when it is less difficult for her to balance her checkbook than to wait patiently for her turn (p. 283).

These examples exemplify the problems autistic children have with adapting behaviors to particular persons or situations, and conforming to the basic rules of social interaction. The goals of intervention within the communication-based approach address problems with social interaction and interpersonal communication as well as problems in the use of language structures.

Goals for Older Children - Communication-Based Approach

Language Goals

1. Teach the child basic word order rules to facilitate the use of words in sentences beginning with the functional phrases such as more (____), and want (____).
2. Teach the use of several grammatical markers and verbs simultaneously (e.g., is +____ing, was +____ing, can + ____, want to ____, etc.) to emphasize the variability of grammatical structures (see Blank and and Milewski, 1981).

Communicative Goals

1. Teach the child some means, either eye contact, using proper names, or some exclamation, to obtain listeners' attention.
2. Teach the child some means, such as head nods, "uh hums," smiles, or other signs of approval, to respond to speakers during conversation.
3. Teach the child to modify his or her behavior in response to listener signs of approval or disapproval.
4. Teach the child to adhere to conventions of conversation such as the need for politeness and the need to use utterances that are appropriate for the social context.
5. Teach the child to switch communicative styles or topics of conversation depending on the listener or social situation.

These general goals address only some of the social interactional and communication problems of autistic children. Once children reach this stage of development clinicians and teachers must be aware of possible problems and attempt to identify those that are most detrimental for the individual child.

Summary

In this part of our presentation, the general outline of an intervention program that approaches language in the context of its communicative functions and social-motivational and cognitive bases was presented. To illustrate the differences between this approach and more traditional language intervention approaches, I have identified possible intervention goals for nonverbal and echolalic autistic children, autistic children who are using single words, and autistic children who are speaking in sentences. In the final part of our presentation, Lacy will suggest some ways in which language and communication intervention can be accomplished in the classroom.

CLASSROOM-BASED LANGUAGE INTERVENTION

Before PL 94-142 became law in 1975, one would have had considerable difficulty finding any mention of a classroom-based language intervention program. During that time, the traditional model of speech-language services was to supplement a predominantly academic curriculum in both regular and special education classrooms. Consistent with this service model was the theoretical model of language disorders which stressed the syntactic, semantic, and phonologic aspects of language rather than the communicative (pragmatic) aspects of language. These services and theoretical models functioned to maintain the previously established division between the domains of special educators and speech-language pathologists.

This division began to dissolve with the implementation of PL 94-142. Also contributing to new collaborative efforts between special educators and speech-language pathologists (SLPs) was a theoretical shift to communication-based language programs that emphasized the social and communicative aspects of language rather than the grammatical appropriateness of speech. These collaborative efforts continue today, as exemplified by this presentation at this conference. The increasing cooperation between special educators and SLPs has benefited both disciplines. Special educators have become more sensitive to the importance of language and communication skills for academic and cognitive performance and have, with the help of SLPs, learned how to enhance the communicative experiences of the children in the classroom. In the same vein, SLPs have become more aware of children's academic programming and daily routines and have, with the help of the special educator, learned how to devise language programming that takes advantage of the various classroom activities.

In the optimal classroom, the SLP works closely with the special educator in the assessment, planning, and programming of language, communication, and academic goals. The SLP might often demonstrate appropriate language intervention techniques throughout the school day in order to provide a model for the special educator from which to learn. During this time, the SLP is becoming aware of the academic skills of these children and the methods the special educator uses for instruction. By continuing to draw and learn from each others' expertise, the special educator and the SLP become better skilled at teaching handicapped children.

Consistent with the previous sections of this paper, we believe that a classroom-based approach which incorporates the components of the communication-based approach is preferred over other approaches and therapy models. Traditional speech-language therapy with the clinician one-on-one with a child in an often sterile, unnaturalistic environment generally is not as effective as a communication-based therapy approach that is conducted throughout the school day in the classroom and other naturalistic settings (e.g., the playground, cafeteria, gym, etc.) with the cooperation of the special educator and other individuals who interact with these handicapped children.

The classroom provides countless opportunities for children to learn, practice, and master social and communicative skills. As suggested earlier, it is these social and communicative skills that should be the focus of language intervention for autistic children. Social and communicative skills are the foundation on which improvements in language and cognitive abilities must build. With the help of the SLP, the special educator should organize the classroom to insure that there are many planned situational contexts that encourage children to use social and communicative skills. Leisure play activities involving group cooperation, mealtimes, and small-group problem-solving situations all are conducive to social interaction. (See Adler et al., 1982 or Peck & Schuler, 1983, for more specific examples.) In instances in which the SLP might have worked individually with a particular autistic child, these naturalistic situational contexts provide an immediate opportunity for the child to generalize recently acquired language or communication skills.

CONCLUSION

It is our hope that this presentation has provided some guidelines for the assessment and treatment of autistic children's deviant language and communication behaviors. It has been emphasized throughout this presentation that effective language intervention depends on an accurate and comprehensive assessment of language and language-related behaviors. The point was made that autistic children are a heterogeneous group of children who display dissimilar language and cognitive skills. Language intervention, therefore, must be designed with an individual child's strengths and weaknesses in mind. Also emphasized in this presentation was the importance of language intervention that is communication based rather than structurally/grammatically based, using non-operant procedures whenever possible. Autistic children must first develop some preliminary social and interactive skills in order to make the language they produce meaningful. Finally, we suggested that an optimal environment for language intervention is the classroom. For this reason, it is our sincere hope that collaborative efforts between SLPs and special educators grow more frequent in the years to come for these efforts are in the best interests of the children we serve.

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VISION SCREENING FOR THE SEVERELY EMOTIONALLY DISTURBED STUDENT

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Today the majority of public school systems provide vision screening for all first grade normal children. Many school systems continue to offer this screening on a regular basis to normal elementary school children. Sadly, there exists an entire population of children who do not receive this service. This population includes severely emotionally disturbed, retarded, and physically handicapped children. The primary reason for this lack of screening service is that most vision screeners simply do not know how to screen this population of children. The purpose of this paper is to describe various methods for providing vision screening to the severely emotionally disturbed population. Also a discussion of ways to set up referral and follow up services will be included.

Approximately 50% of the normal population or half of the people over the age of three wear some type of corrective lens (American Societyto Prevent Blindness). Fletcher and Thompson (1961) and Woodruff (1977) reported that 68% of educable mentally retarded and 90% of trainable mentally retarded children in their studies showed evidence of some visual impairment. It appears that between 75% to 90% of all persons with severe handicaps have a vision impairment (note 1). The more severe the primary handicapping condition, the more likely that there will be other handicaps, possibly a visual handicap.

Consider the dilemma the severely emotionally disturbed student may be encountering. Not only is the student faced with the inability to interact with the world around him due to his emotional handicap but also he may be receiving a very distorted view of that world. Surely it is difficult enough for this student to cope with his daily life much less deal with a vision impairment as well. Granted severe emotional handicaps do not vanish over night, but visual impairments, once discovered and treated, may disappear rather quickly. Since normal persons can receive rapid evaluation and treatment of vision problems it follows that no less service should be available for the severely emotionally disturbed person. How can this service be provided to the severely emotionally disturbed student?

The most effective indication of visual impairment is visual acuity. Visual acuity is the ability of the eyes to perceive the shape of objects in the direct line of vision and distinguish detail. Visual acuity is measured by specific subjective tests. These tests are subjective because they require a judgment and corresponding response from the person being tested. The format for all tests for visual acuity show the size of the test target decreasing in size until the individual can no longer distinguish the target clearly.

Most visual acuity tests use a 20 foot distance as the standard for testing for point or distance vision. Here begin the problems in screening the vision of the severely emotionally disturbed person. The response required to perform this task is referred to as a displaced response. Most severely emotionally disturbed students are not capable of standing with their heels on a line much less looking 20 feet away at a chart and giving a correct response. Therefore, the vision screener must be able to determine what response the student can give and how to elicit that response.

Before a severely emotionally disturbed student can receive vision screening there are some prerequisite behaviors that must be present. The student must have an operant response. That is, the student must be able to indicate an affirmative or negative response. Whether this be a verbal response or a physical response is not important. Rather the response must be consistent and the vision screener should be able to discuss this response. Also, the student must be able to sit and attend to task for a short period of time. Screening sessions can be as short as three to five minutes, but the student must be able to attend for that time period. If the student does not have the above prerequisite skills then his vision cannot be screened until they are attained. It should be pointed out that it is not the role of the vision screener to train these skills. Those persons responsible for the daily programming of the student should be targeting these responses as critical to this student's skill levels.

Once the student has these responses in his repertoire the vision screener must match the visual acuity test to the student's abilities. To determine this match the screener must pretest screening options. This is easily done. The screener may hold the target stimuli close to the student and ask him to give the required response for each stimulus. If the student cannot respond correctly to all stimuli then the screener should try another visual acuity test.

Many vision screening instruments require an answer to a question such as "Which way is the E pointing?" Most severely emotionally disturbed students are unable to respond to this type of instruction. Also it is possible that the screener is measuring the student's inability to discriminate rather than to see the test target (Cress, Spellman, DeBriere, Sizemore, Northam, & Johnson, 1981). Those responsible for the daily programming of this student can train the necessary discrimination. And since discrimination training is a major area of learning for the severely emotionally disturbed student, the student will learn a discrimination skill as well as have his vision screened successfully.

One other important point concerning the actual vision screening process is the modification of the student's response. Several vision screening instruments will allow a match as well as a verbal response. By providing copies of the largest size test targets to the student, the screener can hold up the test target and ask "Show me one like this". The student can simply point to the correct choice. For those severely emotionally disturbed nonverbal students this will be an appropriate response to employ during screening. It is also permissible to reinforce each correct response during screening. Regardless as to the type of reinforcement it will certainly increase the student's on-task behavior.

After the screening is completed another set of problems occur. How does the screener insure the successful referral and treatment of the student with a possible visual impairment? Vision screening is the first step in discovering and treating vision impairment. Based upon the score the student will or will not be referred to a professional eye examiner for a suspected vision problem. Usual criteria for referral is a score of 20/40, or worse, or an obvious sign of vision problems such as red eyes, crossed eyes, constant rubbing of eyes, etc. The professional eye examiner will perform an objective exam usually consisting of a retinoscopy and opthmalmoscopy. For the normal person this examination presents no particular problems. But for the severely emotionally disturbed student a myriad of problems may occur.

Many optometrists or ophthalmologists are not prepared or are not willing to perform an objective examination to a student whose behavior is difficult to manage. The vision screener must seek out those eye professionals who are willing to attempt to examine a severely emotionally disturbed student. Many times those professionals who routinely examine young children may be more willing to examine the severely emotionally disturbed student. These professionals are pediatric or developmental ophthalmologists. The vision screener or teacher of the student should be available to help manage the student during the examination.

Once the student has received a professional examination, treatment may be necessary. This treatment usually results in a corrective lens prescription. The vision screener may be able to aid in determining the exact prescription of a nonverbal student by retesting the student's vision using trial lenses and the estimated prescription. The reporting of screening results to the eye professional and this cooperation between the two will result in an accurate prescription for the student who cannot verbally indicate which image appears clearest.

Some of those severely emotionally disturbed students who receive eye glasses may not be able to wear them immediately. They may require a specific training program in the wearing and care of the eye glasses. Specific behavior management programs may be necessary to teach the wearing of glasses for lengthy periods. It is important that those training programs be used in all environments in which the student interacts. Teachers may instruct parents or other staff members in the methods of implementing and maintaining glasses wearing.

Once this system has been implemented, the severely emotionally disturbed student will no longer be denied an extremely critical service. The ability to function fully in any environment requires adequate vision and no student, even those who are severely emotionally disturbed, should be denied the ability to attain his fullest potential.

Reference Notes

Note 1. Spellman, C.R., DeBriere, T.J., and Cress, P.J. Final Report, from the project Research and Development of Subjective Visual Acuity Assessment Procedures for Severely Handicapped Persons, BEH Grant #G00-76-02592, 1979.

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A VOCATIONAL PROGRAM AND SKILL ASSESSMENT FOR SEVERE/PROFOUND MENTALLY RETARDED AND EMOTIONALLY DISTURBED RETARDED ADULTS

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Description of targeted population surveyed:

Residents of a facility such as Arlington Developmental Center (ADC) have a primary diagnosis of mental retardation. As in normal populations, MR populations are susceptible to a full range of personality disturbances. However, the presence of mental retardation decreases the diagnostic significance of abnormal behavior that is considered indicative of an emotional or psychological disorder and few residents have an actual dual diagnosis. In mentally retarded populations, emotional disorders are generally considered to be a consequence of intellectual deficiencies (Reiss, Levitan, Syzxxko, 1982) while in normal populations such disorders are not considered a function of intelligence. In a survey conducted at ADC of 234 residents, 49 were identified as exhibiting behaviors indicative of emotional disorders (20%). Only 34 residents have an actual dual diagnosis (14½%).

For the purposes of this paper, criteria for establishing the existence of an emotional disturbance were dual diagnosis, the need for psychotropic drugs to control violent or self abusive behavior, the presence of 2 or more autistic behaviors engaged in more than 50% of the time, and severe and chronic self abuse. Table II further breaks down the emotional disturbances into classes surveyed. **(Table not included in this paper.)**

Of the 49 residents identified in the target population, 20 are not eligible for vocational placement because they are of school age (13), below entry level functioning and/or exhibit behavior disturbances (7) of a severity to interfere with vocational training.

The remaining 29 emotionally disturbed residents function primarily in the top third of vocational ability and have a recognized need for further training in vocational areas. They are trained in sequentially developed work related vocational skills within the facility and off campus, where appropriate, to promote development that can lead to remunerative employment in group home placements and sheltered occupational settings.

The need for new evaluation measure for a changing program:

The program at ADC serves the severely and profoundly mentally retarded including those individuals who are emotionally disturbed. The training requirements, for successful work adjustment, are quite varied and broad in scope. It was felt there was a need to expand the curriculum to more fully address social skills, survival, self-care and community life skills to better prepare a resident to cope with higher level vocational programs and actual employment situations.

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The previous vocational training program consisted of levels 1,2,3 and 4 with individualized training provided for 45 minutes for each resident at levels 1 and 2. Levels 1 and 2 were prevocational. There was little movement between levels and those who did not advance created a bottleneck for those who were waiting to enter the program. Individualized instruction, while providing an excellent student/teacher ratio, permitted a limited enrollment with many in need of training waiting to enter. Enrollment was based primarily on available space rather than on vocational aptitude. The present program consists of Work Activity (prevocational), Advanced levels and Vocational Academics, utilizing a small group training format of 4 - 6 residents at entry level and 8 - 10 in advanced levels.

In addition, the curriculum was expanded to address self-help, social/affective, communication, community life as well as vocational domains. Those residents who have reached their maximum performance at a low vocational level may remain on that plane while others, who evidence greater vocational aptitude, move into the program and are channeled, after initial training, into Advanced Vocational and, in some cases, continue on to community placement.

Curriculum objectives:

The Prevocational/Vocational Training Program is committed to the development of the whole individual through exposing residents to the world of work; assisting in the development of good work habits and positive attitudes toward work; helping in the development of some degree of self sufficiency and, above all, helping to develop a sense of self worth.

Bench work tasks develop fine and gross motor coordination through simple tasks such as: stringing beads, pegboards, stacking blocks and form matching. The program exposes residents to a simulated workshop situation in order to help them increase work skills.

Horticultural training acquaints residents with daily care of potted plants and methods of propagation, gardening and harvesting.

Residents are trained in janitorial skills. They cooperate in working with peers and staff. Training emphasizes reduced staff intervention, increasing work stamina, developing appropriate work-related behaviors.

Subcontract work develops work skills, quality control concepts, and social affective behaviors expected in a sheltered work environment, and increases on task time and work endurance.

The area of Practical Life introduces residents to basic simple hand tools and their use, sewing for simple mending and elementary food preparation.

The major emphasis in the Work Related domain of vocational training is in social skills. Training includes attending to work task, working independently and cooperatively with others and following instructions. Survival skills are taught. Residents must learn to respond appropriately to a fire alarm and use safe procedures with tools. Other survival skills include use of money and basic time concepts. Developing independence in toileting and in travelling to and from the work area enables a resident to function more appropriately both within the residential setting and in the community.

Training in the Leisure Skills domain leads to more appropriate and constructive use of free time. Such activities might be participation in team sports, rug hooking, playing simple board games and dancing and working jigsaw puzzles.

The new evaluation program:

A new evaluation program was needed to estimate vocational aptitude and individual progress through the expanded curriculum. This evaluation consists of the initial (and annual) screening instrument, testing materials and the curriculum checklist. All residents are now screened for evaluation of vocational status at the annual programmatic staffing, regardless of age, and appropriate recommendations are made. In the event of referrals, additional evaluations are made and the Interdisciplinary Team is informed of the results. This system enables staff to make programmatic decisions regarding training to prepare residents for future entry into the vocational program and serves as a valuable resource to academic teaching staff. For those residents presently served by the program, vocational evaluation is based on daily training data, monthly progress notes, quarterly reports, formal and informal observation, and the curriculum checklist used to chart all attainments resulting from formal criterion based goal plans and informal activity work. The evaluation program developed consists of:

-evaluation packets to ascertain entry level skills for prevocational and vocational levels. They are used to assess skills annually for each resident.

-a brochure explaining scoring and a materials list are included.

-a curriculum outline serves as a guide for the program staff.

In the initial assessment, the Vocational Work Activity Program probes for physical evidence of sufficient eye/hand coordination and bilateral use of hands for manipulation of work materials, a well developed palmar and pincer grasp, the ability to grasp and release materials on command, enough gross motor development to permit trunk control, and strength to move work materials about. A potential student must demonstrate the capacity to reproduce a demonstration, beginning discrimination skills, endurance to functionally withstand thirty minutes of work on a variety of tasks, sufficient attention to a given task to attend to work for ten minutes with a minimum of prompting, and the ability to remain at the work station for twenty minutes. A resident must be able to understand and follow a simple one step command with minimum prompting and have the ability to make basic needs known through gestures, sign language, Bliss symbols or verbal language. In addition, a resident must be willing to comply to a request within 60 seconds and neither display nor engage in disruptive or self-stimulative behaviors more than ten percent (10%) of the time.

To enter the Advanced Vocational Program, a resident must demonstrate fully developed eye/hand coordination, grasping (palmar/pincer), reaching and releasing skills, bilateral use of hands and gross motor control. In addition, the student should demonstrate vocational skills in packaging, assembly, disassembly and collating. The resident must display well developed discrimination and imitating capabilities, and the capacity to functionally withstand three to six hours of work, attending to work independently for one hour, and remaining at the work station for 90 minutes. The resident must be able to make basic needs known without assistance, respond to name when called and follow simple two step commands. The student should be willing to comply to requests within ten seconds and work cooperatively with a group of five or more with some supervision. Disruptive or self-stimulative behavior must not occur more than five percent (5%) of the time.

The characteristics assessed in the evaluation instruments were judged by consensus of departmental staff to be essential prerequisites for successful training in vocational areas. The program provides sequentially developed skill training that leads to competitive or semi-competitive employment. Residents are trained to develop good work habits and a positive attitude toward work. Other program aims include developing a degree of independence in personal care and self-sufficiency in work skills.

The new evaluation program is itself undergoing an assessment period. During this time its validity, efficiency and accuracy in projecting vocational aptitude are being judged and norms established.

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Creative Drama for Autistic Adolescents: Expanding Leisure and Recreational Options

The range of services needed by autistic and autistic-like adolescents extends to the provision of appropriate recreation and leisure opportunities. To achieve this end, opportunities must be structured to accomodate the developmental deficit in imaginative play behaviors which tends to characterize this population (Knoblock, 1983; Koegel, Rincover, and Egel, 1982; Kugelmass, 1970; Michelman, 1974; Oppenheim, 1974; Roberts, 1977; Wing, 1972). The autistic adolescent's inability to organize leisure activities, to creatively and constructively use free time, and to participate in social experiences, can be viewed, in part, as symptomatic of having not learned how to play (Elgar, 1977; Uline, 1982; Wehman and Schleien, 1980). Programs and activities which incorporate training in how to play, however, can expand and enrich for autistic adolescents the repertoire of appropriate leisure and recreational options.

One viable program alternative for autistic adolescents, creative drama, incorporates play training with recreational and educational group activities. With certain modifications,standard creative drama activities can be used to promote appropriate leisure and recreational behaviors in autistic adolescents. The goal of this paper is to describe how creative drama activities can be structured developmentally to meet the specific needs of this population.

Principles of Creative Drama

Creative drama, the informal branch of children's drama, is defined as those forms of improvised drama played with spontaneous dialogue and action

(Duke, 1973). The recreational and educational applications of creative drama have involved all age groups and have used structured activities* to provide participants with immediate and dynamic experiences interacting with others, rather than produce theatrical presentations for an audience (Faulkes, 1975).

The underlying process of creative drama is the spontaneous dramatic play of young children, the guided dramatic play of older children, and the improvisational games, characterizations, and dramatizations which arise from interacting with the environment (McIntyre, 1974). With these natural processes serving as a foundation, creative drama exercises and activities can be sequenced so as to mirror the natural developmental stages of childhood play (Warger, 1983).

Creative drama begins with basic warm-up or sense awareness activities, which are used to stimulate participant exploration and response to multi-sensory stimuli, and which can be seen as analogous to the sensorimotor manipulation stage of infants. Following warm-ups, creative drama participants are encouraged to copy movements and sounds within the environment, behaviors which are similar to those executed during the imitation play stage. As ability to imitate increases, pantomime activities, the content of which parallels symbolic play behaviors, are attempted. Pantomime participants first pretend to use objects, and then become those objects (or persons or animals). Once pantomiming skills are proficient, characterization and dialogue opportunities are expanded, with story ideas presented for play-acting or improvisation. At this point, activities begin to resemble the content of sociodramatic play.

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*It is assumed that the reader has a basic knowledge of creative drama activities and exercises. The following authors provide excellent background information: Barnfield, 1968; Behr, Snyder, & Clopton, 1979; Cottrell, 1979; McCaslin, 1974; McIntyre, 1974; Spolin, 1963; Ward, 1957.

Creative Drama

The use of creative drama activities can be seen as serving a dual purpose. Besides providing a unique recreational and leisure option, it also provides a medium for fostering those skills resulting from natural childhood play which may have been arrested or underdeveloped in autistic children. Participants can become more aware and capable of using their senses, voices, bodies, emotions, imaginations, and intellect, in addition to developing social skills (Behr, Snyder, and Clopton, 1979; Hensel, 1977; Jennings, 1978; Shattner, 1967; Shaw and Stevens, 1979).

Guidelines for Accessibility with Autistic Adolescents

Severely handicapped children and youth do not explore, investigate, and experiment in the same manner as their nonhandicapped peers (Vaughan, 1979). In order for many sensory stimulation and symbolic play experiences to be accessible to autistic adolescents, adults often are needed to initiate and structure activities (Knoblock, 1983; Michelman, 1974; Moran, 1979; Roberts, 1977). Thus, creative drama activities must be structured appropriately to meet the specific needs of this population. Both the task content and the adolescents' particular strengths and weaknesses as they relate to the chosen activities must be analyzed prior to planning instruction.

Analyze activity content. The creative drama task first must be analyzed for conceptual content or level of play behaviors. The particular level of play, sensorimotor, imitation, symbolic, or sociodramatic, represented in the activity is determined at this point. This determination aids instructors when selecting appropriate activities to meet goals and objectives.

A standard creative drama activity, pretending to jump an imaginary rope in a group, will be used as an example to demonstrate how a conceptual analysis is completed. The basic activity, which requires sociodramatic play behaviors (participants collectively engage in a pretend activity where movements represent the rope), may be reduced to the following component activities:

- Using an actual rope, hold and turn it, see it being turned, hear it touch the ground, etc. (sensorimotor/imitation)
- Imitate the instructor jumping an actual rope (imitation)
- Imitate the instructor holding and turning a pretend rope. At first, objects with varying degrees of similarity may be substituted for a rope (imitation/symbolic)
- Imitate the instructor jumping a pretend rope (imitation/symbolic)
- Jump a pretend rope (symbolic)
- With a partner, turn a rope (sensorimotor)
- Jump a rope being turned by two people (sensorimotor)
- With a partner, turn a pretend rope (symbolic)
- Watch two people turn a pretend rope and stamp each time the pretend rope hits the ground (symbolic)
- Jump a pretend rope that two people are turning (symbolic/sociodramatic)

While this list of component parts is only a sampling of the many possibilities, it does illustrate how a basic activity may be conceptually analyzed. Given this conceptual information, instructors have a basis for modifying basic activities to accomodate a particular group.

Activity content also must be analyzed for interest level. Care must be taken to ensure that participants have an adequate experiential base with which to understand the content. In addition, the motivational aspects of content must be scrutinized. For example, content should allow participants opportunities to perform movements and implement skills which are enjoyable. Further, it must be determined whether or not the content will appeal to the age and sex type of the group.

Finally, the format of the activity must be analyzed for prerequisite skills. If the activity involves manipulation of materials, then the particular perceptual-motor skill level necessary should be assessed. The input and output modes, whether they be visual, auditory, kinesthetic, or olfactory, required of the participants to complete the task must be specified. Learning and adaptive behaviors, such as attending to task, attention span, initiating behaviors, independence, etc., also must be considered. Additionally, the social interaction requirements (e.g., small or large group; one-on-one) must be stated.

Respond to Adolescents' Needs. The key to making activities accessible to autistic adolescents lies in the appropriate determination of structure. Once the activity is analyzed, participants' relative strengths and weaknesses must be scrutinized for instructional implications. For each element of activity analysis, it must be determined whether or not participants possess the abilities required for successful performance. This preliminary procedure of matching student abilities with task content and format is essential for planning appropriate instruction.

Of critical concern is the level at which participants are able to produce play behaviors. Although some higher functioning autistic adolescents will know the meaning of the pretend command, they still may need more experience and guidance if they are to be proficient complying with it. For this group, a large selection of activities representing sensorimotor and imitation stages in conjunction with those at the symbolic stage, will be helpful. For those autistic adolescents who have difficulty imitating behaviors and sounds, a large number of activities, in addition to several activities which incorporate adult instruction with imitation, will be appropriate. Overall, instructors need to choose more activities which participants can easily master, to counter balance those which require more effort.

Autistic adolescents manifest a variety of adaptive behaviors and evidence a wide range of abilities which also will affect the selection and implementation of creative drama activities. Instructors can utilize participants' strengths and abilities by designing and choosing those activities which provide constructive outlets for particular behaviors. For example, if an adolescent group enjoys music and rhythms, experiences incorporating this medium can be chosen (e.g., imitate rhythms; make rhythms with objects; move specified parts of the body to music). Or, if a group enjoys olfactory input, then smelling or tasting components can be integrated constructively into activities (e.g., a camp scene where pine air freshner can be smelled and freeze dried foods can be tasted).

Instructors also should accomodate individual needs when designing activity format and presentation sequences. Generally, autistic groups benefit from short and similarly sequenced sessions, where activities are varied according to group attention span. For example, even though a number of tasks are to be presented, the same introductory and closing activities should be used for each session. Further, routine can be built into sessions by repeating several activities that participants have mastered. The seating structure and transition time additionally can be structured similarly each time in response to the need for sameness (e.g., chimes are sounded, the instructor states that it's time for creative drama, participants move their chairs into a circle).

Attention also must be given to grouping. For beginning groups, a ratio of one adult to one or two adolescents often is needed. Adults serve a dual purpose: one as instructor; the other as a model for play behaviors. Moreover, as activities are designed with enjoyment as a goal, it is critical for social development that pleasure obtained from the experience is linked to the participation of others. Thus, circle seating arrangements are useful for fostering a sense of groupness, as well as for interaction.

For pleasure to be obtained from the experience, group interests must be integrated into the activities. In fact, the most successful activities generally are built around topics and incidents from participants' lives. For example, chores lend themselves particularly well to pantomiming and story-making. If the group has a particular interest, capitalize on it by designing an activity around it (e.g., if the group enjoys bus rides, set up the chairs like a bus and pretend to take a ride; if cooking is of interest, pretend to cook their favorite foods). To increase involvement in activities, stimulating or novel objects are useful. With the guidance of an adult, these objects can be explored, experimented with, and finally used to stimulate imitative and symbolic behaviors. Unusual hats, strange costumes, and colorful jewelry all tend to lend themselves to dramatic exploration.

Putting it All Together: A Case Study

The following examples describe how creative drama activities can be adapted for a group of adolescents with autism or autistic characteristics. The particular activities all have been used in a community recreation program serving autistic and autistic-like adolescents. To illustrate how activity restructuring fosters accessibility, the standard creative drama activity will be presented with an analysis of its content and suggested modifications for use with autistic populations.

Activity: Object Transformation. Participants are presented with an object and instructed one at a time to transform the object by pantomiming another use for it. (e.g., a soup ladle becomes an umbrella or a microphone; an automobile part becomes a transitor radio or camera). After each person demonstrates their imagined use, the group guesses what the object has become. The play stage represented in the activity is symbolic. To complete the task, participants will need the following abilities: response to and understanding of verbal commands; response to visual input with physical output; concentration and focus on others' movements; ability to work independently in a large group.

To adapt this activity for adolescents functioning at an imitation stage, the first step involves restructuring the play behavior content. Attention also must be given to modifying the independent group-work format. Thus, the activity can be adapted in the following way. While seated in a circle, participants are instructed to focus on the group leader. The same stimulus object is presented to each participant. The instructor moves the object and the group copies the movements. Next, one-at-a-time, each adolescent produces a movement with the object, which the group copies. It should be noted that some adolescents may benefit from actual manipulation of the object prior to producing a movement on command. As participants become proficient at copying, the question, "What else could this object be used for?", may be posed. At this point, adults may be needed to suggest ideas and guide responses.

Activity: Mirror. In Mirror, pairs imitate people looking into mirrors. To achieve this end, one partner pretends to be a mirror image of the other. The play stage represented in this activity is symbolic, with some sociodramatic elements. To complete the task, the following abilities are needed: response to and understanding of commands; response to visual input with physical or motor pace; concentration; ability to work in pairs with one leading and the other following.

This activity can be modified for a group working at either a sensorimotor or imitation stage. Holding onto plastic dowels as they sit facing one another, pairs (adolescent and adult) move to music. After moving together at will, the adult announces, "You move, I'll follow". Next, the adolescent is asked to follow the adult's movements. As skill develops, the dowels can be removed and the adolescents instructed to move a part of the body while the adult copies the motions. Roles are then reversed.

Activity: Sound Effects. In groups, participants make up a story and "tell" the story through the use of sounds. For example, a story about a haunted house may sound as follows: footsteps, hesitating, a knock at a door, low moans and faint laughter, a door opens, more moans, a cat screech, chains rattling, footsteps, a loud "Boo!". The play stage represented in this activity is sociodramatic. The following abilities are needed to complete the task: Responding to and understanding of commands; response to auditory input with verbal or physical output; listening; developing a story; understanding the concept of a haunted house; working together in a group; performing on cue.

To adapt this activity, participants first might need to explore sound-making on a sensorimotor level, **therefore** objects **might be presented** for participants to make sounds with (e.g., bounce a ball; open an envelope). Alternatively, participants could listen to sounds and identify them. On an imitation level, sounds could be replicated, much the same as movements were in the object transformation activity previously described. A short (five to six sentence) story involving common sounds could be written for participants to respond in sound to. For instance, a story might read as follows,

> You're thirsty and so you walk into the kitchen (footsteps). You pour water into a cup (water is poured). You add a scoop of Kool-aid and stir the water (spoon stirs in cup). You taste the water (drinking sound). It tastes terrible!

Conclusion

Providing appropriate recreational and leisure opportunities to autistic adolescents presents professionals with a unique challenge. Due to the nature of the handicap, play development may have been arrested or slowed in early years, thus limiting the range of leisure experiences available during adolescence. Creative drama offers a viable recreational program option, as well as an instructional means for developing play behaviors. By treating the creative drama activity content as representative of developmental play stages, and by capitalizing on the adaptive behaviors and skills of the participants, activities can be structured and sequenced to ensure success. Further, since the activities require academic and social skills, they can be used to reinforce learning and to provide a unique format for skill practice.

All children and youth, handicapped or not, need the opportunities and experiences offered by the creative arts. With modifications, creative drama can make these valuable opportunities and experiences accessible to autistic adolescents.

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Motivating the Emotionally Disturbed/Learning Disabled Child: From a Model Program Approach to Practical Teacher Application

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This presentation provided conference participants with an example of a model program using a multi-disciplinary team approach to serve ED/LD children and adolescents. This program includes education therapy, occupational therapy, behavior management, and related areas. The description of this innovative approach to teaching this population included practical ideas for teacher adaptation of techniques for use in classroom settings where multi-disciplinary resources are not available.

WHAT WE WISH THEY KNEW

David F. Freschi
Executive Director
CAMARY Corporation

One of the inevitables that face handicapped children is the same experience that so called normal children experience ---that children become adults. They become adults with parents who have grown older and siblings that have begun to seek their own independent lives. The special education teams and classes disappear to be replaced by an occasionally bewildering array of service agencies.

A question that comes to mind but seems rarely to be asked is...did we do a good job? Have the placement meetings, the special classes, the laws, due process, mainstreaming etc. paid off? Can the families of these now grown children begin to sleep a little better secure in the knowledge that their child, now adult, realized a great deal of their potential?

At CAMARY, an intermediate care facility for autistic and similar developmental disability adults we decided we would ask ourselves these questions. We felt we had a unique opportunity to do this. CAMARY is a little more than a year old and its population of fourteen adults is relatively young (18-33) and includes clients from both public school backgrounds and institutional settings. In addition the agency's classification as a 24 hour all inclusive program with an extremely strong data base allows it to use under one roof a very complete professional and paraprofessional team to get an in-depth picture of the clients' real strengths and needs. What follows is a summary of what our answers were to the questions above and what we wished our clients had learned before they became adults.

From the start there were indications that this group of clients, admittedly an extremely difficult group to work with, had some problems that would have been best dealt with at a younger age. The records alone began to tell a story that was disheartening in this supposedly enlightened day and age. The records were, to say the least, voluminous. Content was another matter and one wonders where all the advocacy efforts were going. In general there were five common problems in all fourteen records that made our initial job difficult.

Repetition of Goals & Objectives: There was a consistent pattern of goals and objectives in IEP's (Individual Educational Plans) being repeated for two, three, and sometimes five years from placement to placement. The amazing part of this was that each year most of these objectives were reported as accomplished.

Medication: Thirteen of our clients arrived on various levels of psychotropic medications which had been authorized to "help" them control their problem behavior. The common strand was that from mid-adolescence on, levels and dosages gradually increased. One year later those same 13 clients had had their levels of medication reduced by 60% without ill effects.

Limited Outlooks: In general, goals over the years were set with very limited expectations. We saw clients whose records indicated such things as a goal of 10 words to learn to sign in a year, or writing five letters, or two to three steps of a self-care sequence.

Critical Outlook Towards Parents & Families: This is admittedly a subjective opinion based on interpreting the tone of language used in various reports. The recurring theme seemed to be what parents needed to learn, to be trained in, to come to grips with, etc. It seemed to be funny language for the partnership that 94-142 was to usher in.

Careless use of the term Independent: While one can understand the desire and obligation to give the handicapped child all the credit that is reasonably due, the effect of declaring someone fully independent when they are not can be cruelly destructive in the future. Many of our clients' records indicated that they were independent in several areas. Often this was not the case. The result of this careless use of the term independent was time wasted, denial of services which then had to be renegotiated and placement of clients in situations that guaranteed traumatic failure.

When we got to actually working specifically with our clients several areas came to light during this first year. The examples that follow are representative to varying degrees of all the clients we serve.

The first and one of the most frustrating areas was self-care. Take the case of Ralph. Ralph is 24 years old, non-verbal and has a history of school and institutional placement. According to Ralph's record he is either totally independent in toileting or requires "infrequent" supervision. Well he was independent. He could independently go to the bathroom up to 40 times a day and independently smear most of those times while managing to plug the toilet. At one level there's a bit of humor here but only a bit. Having worked with both children and adults this author can assure the reader that a 175 pound aggressive individual is very difficult to toilet train pleasantly or easily. The tragic part is that during his smearing activities Ralph injured himself and a tremendous amount of time was spent and is being spent on a skill that, though a little non-exciting, is essential and could have been much more easily taught when Ralph was small enough to safely contain.

Jane gave us another example of the problems limited expectations can cause. Jane is 19 and among other problems has spina bifida. Therefore she has legitimate difficulties with toileting.

These difficulties shouldn't mean that toileting and independent or semi-independent hygiene should be ignored. Jane however, arrived completely dependent for all of her toileting needs. Checking her records one finds no toileting goals for at least five years back in her IEP. The only mention one sees of toileting is an occasional note that toileting skills are not applicable due to Jane's physical condition.

Well Jane has been in program for 16 months. She has learned 50% of the steps necessary to independently change her own diapers when soiled and the first step in using a catheter for bladder control. Try laying an adult diaper next to a child size and see which you would rather deal with...

Another area that presented us with problems with our adults was in the whole range of social behaviors. The behaviors that seemed to give the most difficulty were "cute" behaviors, tantrum behaviors, and physical aggression.

Ronnie provides a good example of "cute" behavior that was considered acceptable as a child and, from the tone in his records, reinforced quite strongly. Apparently Ronnie, an autistic young man, would approach people and touch his forehead to theirs seeking attention. This was considered, perhaps rightly so, an attempt to communicate and, perhaps not so rightly, strongly encouraged.

Ronnie is a handsome young man now. He is 19 years of age, six feet tall, and weighs approximately one hundred eighty pounds. We are struggling to turn his "affectionate" approaches into something a little less bizarre and a little safer than his head touching. It is, considering all the past reinforcement, very difficult and costly. The staff has already paid a number of bruises, one broken nose, and one concussion. While we have staff that is well trained and very patient in working with these types of behaviors, it is frustrating to try to de-teach or reshape behavior when the best opportunity would have been years ago. Its also tragic that this "cute" and reinforced behavior of childhood is now one of the very things that helps to deny Ronnie his place in the community.

Herman, 26 years old, presents us with two of our more common problems - cute language and tantrums. Herman has developed over the years a repertoire of language responses that are quite often funny and easily encouraged by the smiles of adults. In fact even though capable of a reasonable level of functional speech he will stick with his patterns of funny language because they have paid off so well in the past. Phrases like "awright put up your hands" and humorous jingles may seem harmless enough until we put them in the context of community life. Responding to a verbal greeting from a passerby with a chorus of "Popeye the sailor man" is not designed to help you fit in to the community. Yet these language patterns have clearly been reinforced over the years and in an adult community residence it is very difficult to prevent this reinforcement from occurring. Herman also displays very classic tantrum behaviors full of foot stamping, sitting on the floor, screeching, etc. Into the midst of these he adds his "funny" language bag of tricks. We're making progress but Herman is 26 years old and tantrums are not a behavioral secret. Where were our skills going when this man was 5, 10, 15 years old? In all those years we in the special education business seem to have been unable to muster the long term discipline to confront these behaviors and help change them. Relatively simple behaviors to deal with at a young age now cripple an adult.

Out and out physical aggression is another problem that confronts us and we are one of the few agencies that can or will cope with this for any period of time. Physical aggression is displayed by 70% of our residents with approximately 40% of that group having the potential for very serious aggression. In each and every case the aggression has been "controlled" by increasing doses of medications and behavioral programs characterized by short term efforts, lack of follow-through and completion. These clients are adults now and while institutional patterns can account for some of the behavior it doesn't account for all of it. Again we are making headway in converting some of this aggressive behavior to positive learning but it is very difficult, and often painful to staff. We operate a non-aversive, positive, and highly structured program. Even in a system of this type confrontation occurs with clients who have had a history of short term success for aggression. It is not pleasant even for those with the skills to get into physical involvement especially when the problem behavior has clearly gone on for years and could have been dealt with.

As we examined our first year and a half of operations and confronted the problems we have come to a few conclusions and possibly some recommendations which might be helpful.

We must learn to consider both the short term and long term results of our teaching. Next year is too close for a goal. We should consider perhaps developing five year goals. These need not be as specific as our one year goals but we must consider where we want the child to be and the realities of adult life. If we fail to plan for adulthood we may find that we have denied our children the fullness of life that they are capable of achieving.

Independence training must focus on true independence for the client. We have a saying at CAMARY that "if you can plug your ears, tape your mouth, close your eyes and tie your hands and the client can perform the task he/she might be independent." If the child cannot perform at this level carefully describe the conditions under which he/she can perform. This will make things much easier for both the client and the staff of the adult program.

Data and records need to be made functional and not just regulation meeting. We employ a system based on Precision Teaching Principles which gives us daily information on rates of learning and skill acquisition, problems, and the influence of behavior programs, and medications. If we had just a little of this information mixed in with the pounds and pounds of not so helpful records we could help our clients much more quickly when they enter a program.

We should closely examine the behaviors of our clients when they are children and consider what those behaviors will be in an adult. From this assessment we should be determining the bulk of our priorities.

Finally we feel that we should be patient with children but stop being patient with ourselves. The children we serve don't have the time for limited goals. They don't have the time for "it takes a long time." They cannot achieve a functional place in the community by acquiring skills at a minimal rate. We must teach, teach more and teach well.

SECTION IV: DESCRIPTIONS OF PROGRAMS

OVERVIEW: Provision of services to autistic adolescents and young adults in a fully integrated high school setting is described by Bernard H. Travnikar, director of such a program. The comprehensive services developed to meet the educational needs of autistic and emotionally disturbed students in a large city system are described by special education consultants and specialists of the Memphis City Schools. In contrast, Daniel B. Rosen, Executive Director, and staff of a comprehensive community based service provider for the developmentally disabled document their success in meeting the needs of autistic individuals in such a facility.

Child Mental Health Services, Inc., a non-profit organization developing and implementing services for the autistic and emotionally disturbed, had as its first service the development of Allan Cott School. This program is described by Betty Milner, director of the school. Dr. Robert J. Devlin discusses a summer school program for emotionally disturbed adolescents in a residential treatment center. Day treatment as an alternative to out-patient visits and hospitalization, for children and adolescents with psychiatric problems, has proven successful in one such program explained by Dr. Laurel J. Kiser, Pamela Rubin, and Cynthia Hill.

The final paper in this section, by Dr. Byron R. Holmgren, details one criterion performance program for preparing teachers of children with learning and behavioral disorders.

SECONDARY LEVEL AUTISTIC PROGRAMMING IN A HIGH SCHOOL SETTING:

DEBUNKING MYTHS AND SUGGESTING IMPLEMENTATION STRATEGIES

Bernard H. Travnikar

Typically, students with autism do not receive educational services in regular educational settings. In most instances, they attend school in isolated settings.

This pattern of service does not reflect the needs of students with autism. Rather, it is a replication of the institutional model which was the dominant approach to meeting the needs of these children prior to the onset of P.L. 94-142.

What was once thought to be a need for "treatment" is now generally regarded to be a need for "appropriate education". Autism, which was once thought to be an emotional illness, is now more properly regarded as a neurological disorder - educators no longer regard the disorder as "childhood schizophrenia".

The current approach is not an attempt to effect a psychiatric repair of the damaged parent-child relationship. Instead, it is an attempt to teach the child to interact as effectively as possible in the community. A highly structured, behavioral approach has come to be recognized as the most appropriate means of educating people with autism. It is time that we as educators and advocates demonstrate to the community at large that the public school is the most appropriate setting.

This will not be easy. The general public, as well as many educators, **harbors** notions about autism that are fabricated out of myth and misconception. These myths cannot be dismissed—without attention they will perpetuate themselves. Myths about autism and the nature of relevant educational services must be identified, and confronted head on. This confrontation must be based on experience and fact, not conjecture.

Frequently, when parents of children with autism ask why their child's education is being provided in an isolated setting, we as educators have responded that "It's what's best for him; it really wouldn't be fair to expose him to non-handicapped students". When parents raise the issues of "mainstreaming" and "least restrictive environment", we have told them that "mainstreaming" really isn't mentioned in the law, and that for "some students" isolated settings really do constitute the least restrictive environment.

Clearly, the need for specialized classrooms and programs is genuine. Isolating autistic programs, however, is neither necessary nor appropriate.

The Oakland schools autistic program is located in Lamphere High School, a regular education facility located in Madison Heights, Michigan. The program provides services for twenty adolescents and adults with autism, ranging from fourteen through twenty-five years of age. Students are referred from any of the twenty-eight local school districts in Oakland County.

The program has operated out of the current facility since July of 1981. Assertions and contentions put forth herein are based on observations and experiences gained while operating in this secondary level public school setting.

Some will content that a student with autism can't possibly function well in shared and normalized school environments. Too many people, too much activity, too varied a routine are reasons frequently cited. Ironically, all the "too many and too much" considerations describe not only the public school environment, but the local community as well. Consequently, they are not reasons why we can't provide autistic programming in such settings; rather they are among the reasons why we must.

In most cases, it will be acquired social skills, even more so than academic skills, that will constitute freedom and opportunity for the autistic population — when a severely developmentally/behaviorally disordered person is in his late teens and functioning academically at a second grade level, it makes little sense to write objectives in hope of raising reading skills to the 2.5 level. Even if this goal were to be attained, it is unlikely that the individual would achieve newspaper literacy prior to program termination.

If, however, the individual learns appropriate audience behavior, cafeteria behavior, crowd behavior, etc., the range of activities that he will have the opportunity to engage in will be far greater than they would have been otherwise. Public school settings are an excellent environment in which to teach and promote such behavior.

In a very real sense, our autistic programs must be "Prep Schools" - we must prepare our students for residential and vocational placements outside the institution.

The nature of these vocational and residential placements will vary widely. To some degree they will be determined by the intelligence level of the individual - in the autistic population this is a wide variable as well.

The nature and quality of post-school placement will also be determined by the level of social skill and degree of social adaptibility the individual is able to exercise. Other than the community at large, there is no better place than the public school to practice such skills.

We do great disservice to our students if we allow them to remain "hot house plants" - able to exist only in the most rigidly controlled environment. Certainly, we must remain cognizant of the extreme difficulty some students experience in coping with the naturalized environment. Yet, we must recognize that programmatically isolating these individuals from the real world is irresponsible; educators deserve the salaries collective bargaining has secured for them, babysitters don't!

Some will go so far as to maintain that "they don't benefit from role models". "They" in this instance, refers of course, to students with autism. Underlying this assertion are several erroneous assumptions. One is the mistaken notion that the autistic population is a homogeneous group - that one can paint the truth about "them" in the broad strokes of a four inch brush. This is not the case. The population is diverse. Anytime we talk about "them", we do a disservice to each individual person with autism. The public school is an ideal setting in which to promote recognition of the fact that in spite of individual differences, "we", handicapped and non-handicapped, are more alike than different.

Evidence of the autistic population's suseptibility to modeled behavior is the institutional behavior that all too many of our students display. Food grabbing and fist brandishing are not on any list of identified autistic behaviors - and yet we see the behaviors in many of our students. These behaviors are routinely displayed in the institutional settings where all too large a percentage of persons with autism spent their formative years.

We don't send children to France to teach them to speak English; why then, do we isolate developmentally disabled people to teach them to live in the community?

Another frequently employed rationale for providing special education services to the severely disabled in separate settings is that it would be unfair to regular students to expect them to share their facilities. Verbal disruption, property damage, and personal assault are often cited as the likely result of placing behaviorally disordered students in normalized settings. Implicit in this expression of concern is the suggestion that such violence and disruption does not already exist in these settings. It would be naive to assume that undesirable student behavior did not, at least to a limited degree, transpire prior to the time when our program was placed in Lamphere High School. In fact, a number of formerly disruptive, **aggressive**, attention seeking regular education students are now motivated to keep their behavior in check so that they can remain eligible to function as student assistants in our program. Strong staffing ratios and appropriate behavior management strategies insure that the behavior of our students does not put other students at risk or facilities in jeopardy.

Moreover, students who graduate from Lamphere High School will not live their lives in fear of developmentally disabled people. Nor will they be alarmed by the prospect of a group home in their neighborhood. The education of normal students is not compromised by the presence of students with special needs - it is enhanced (unless professionals are less than responsible in attending to matters of planning and supervision).

If all the myths that people offer as necessary reasons to isolate certain programs and students were true, there would be little to vindicate the cost and efficacy of such programming.

Fortunately, these myths, like all myths, can be dispelled by experimentation that can be observed and replicated. This paper is presented in the belief that the Oakland schools autistic program is an experiment that will be validated by such criteria. Hopefully, others will deem it appropriate to observe, replicate, modify and improve upon the program model.

Those who choose to do so will have to address a broad issue: the issue is "lack of readiness". Often, individual educators endorse the concept of serving severely developmentally disabled students in regular education facilities, but they express a litany of readiness concerns - the student population is not ready, the faculty is not ready, the administration is not ready, the board of education is not ready. This readiness issue is usually not a myth, but it is usually not a viable excuse to abandon the concept of providing educational services in shared facilities, either.

Those who endorse the concept must recognize themselves as the leading edge of an educational and social movement that is taking place on behalf of all students. Those who endorse the concept must assume the responsibility to plan and organize toward the goal of implementing such ideas. Failure to plan is planning for failure.

A good first step is to identify resource people and "gatekeepers". Gatekeepers are those whose permission or approval must be obtained prior to implementation - administrators and board members usually top the list. Start with those who appear most likely and able to visualize and appreciate the innovative service format that is being proposed. Whenever possible, use dollars as allies; in other words, look for opportunities to support your philosophy with good business sense. Point out the fact that many schools have numerous empty classrooms due to declining enrollment; question whether or not it makes sense to heat two school buildings when both student groups could be served in one building. This does more than reduce operating costs - it also frees the other building up to be used as a potential rental property.

Resource people are those who have needed expertise, or those who enjoy the trust of gatekeepers. University staff members, or staff members from other school districts already engaged in such projects can be extremely valuable. So can vocal parents and highly visible members of the community at large.

When seeking the support gatekeepers, never present the issue as *their* problem - always make it clear that *we* (they and us) have a problem, and that their interest and support is vital. Brainstorm in an effort to anticipate every possible question and concern that may arise from various sectors. Hold public meetings at different times and at different places; use these as forums to discuss the socialization needs of students with autism *and* as vehicles to address questions and concerns. Make every attempt to understand and address reluctance to endorse the concept. Keep in mind that people who have never had much exposure to the handicapped population are frightened and intimidated by the prospect of sharing their daily routine with such individuals.

Never promise that "there won't be any problems". Rather, assure gatekeepers that problems which do occur will be addressed in a responsible manner, and politely insist that the school (rather than the institution) is the place to do this.

Why do we send children to school in America? For three reasons:

1. To help them understand our culture's values and traditions;

2. To afford them with the necessary skills to be successful in career pursuits; and

3. To enrich their lives by exposure to many areas of knowledge and involvement.

I look forward to the time when all our children will have the opportunity to experience each of these benefits in the public school setting. Those of us who share this vision must strive so that this emerging concept will not be a wave that breaks before it reaches the shore.

Elizabeth Montague
City Schools Staff

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PUTTING IT ALL TOGETHER

The Memphis City School System welcomes the opportunity to boast of the programs provided for emotionally disturbed and autistic students. We believe that we have been able to "put it all together" by providing for the needs of the "total child."

PROGRAM FOR CHILDREN WITH SEVERE COMMUNICATION AND BEHAVIOR DISORDERS

THE CHILDREN

The programs are designed for children and adolescents who exhibit severe communication and behavior disorders; typically diagnosed as autistic or psychotic. They often have extreme language impairments, poor cognitive and motor skills, plus inappropriate social development. The frustration often caused by their inability to communicate results in behavior problems ranging from withdrawal to extreme aggressiveness. The children are referred to the city school system and are evaluated by an Assessment Team to insure proper placement.

Residential and/or day school services are provided throughout the year. Programs are open to residents of Memphis and Shelby County between the ages of four and twenty-one.

THE PROGRAMS

Day School

- Major academic program
- Five classrooms offering three graduated teaching levels
- Individualized Education Programs for each child focus on behavior control, speech and language therapy, socialization skills, and academics
- In-community trips expose the students to new and educational experiences

Residential Center

- Provides a twenty-four hour, seven day a week, structured home environment
- Length of stay varies with the needs of resident
- Programs are designed to develop competency in the areas of behavior control, self-help and daily living skills, recreation, vocational skills, and speech and language therapy
- In-community program teaches behavior control in actual community settings

Extended Day Program

- -- Offers training in a structured behaviorally managed environment geared toward serving the individual needs of each child
- -- Specific skills provided in the Individualized Education Program include the areas of self-help, group and solitary play, gross and fine motor, academic tutoring, language, socialization, and behavior
- -- A low pupil-teacher ratio is maintained to assist each child in reaching his maximum potential
- -- Parents serve as active agents in the planning of their child's curriculum

Speech and Language Program

- -- Therapy involves developing a useful and meaningful communication system
- -- Concentration on vocabulary and concept building, sentence structure, rate, vocal quality, and sound production
- -- Individual or small group sessions are taught four times a week
- -- Classroom teachers work closely with speech therapist to up-date goals

Parent Involvement

Parents in all the programs are active participants in the habilitation and education of their child. With parental involvement in developing the IEP, teachers are able to design mutually agreeable procedures, methods, and techniques. This allows for effective management of the child in both the home and the school environment.

Staff

The staff includes teachers who are certified in Special Education on Bachelor and/or Masters levels. The Speech Therapist assists the children in developing concepts necessary for communication skills. A liaison teacher works with parents and teachers to assure full services according to the child's needs. Teacher aides, many of whom are Special Education majors, are a vital part of the program.

CRITERIA FOR ADMITTANCE (to residential program)

1. Child must exhibit severe disorders in both the areas of behavior and communication.

2. The disorders exhibited must warrant individual attention in a structured environment to enable the child to learn a set of skills necessary for responding to grasp instruction.

3. The disorders exhibited must warrant an intensive behavior management program whose major emphasis is on speech and language skill development, self care, socialization and functional pre-academics.

4. The child must have a complete developmental evaluation performed before being placed in the program. This evaluation should include the areas of: pediatrics, psychology, speech and hearing, visual and auditory acuity and perception, and neurology.

5. The child must display a majority of the following broad based symptoms:

   a. Onset of symptoms should be evident prior to earliest school contact.

   b. Gross defects in language development.

   c. When speech is present, has peculiar speech patterns such as immediate and delayed echolalia, metaphorical language; pronominal reversals.

   d. Lack the appropriate social behavior, lack of responsiveness to human beings.

   e. Lack of appropriate play.

   f. Apparent, but unconfirmed sensory deficit.

   g. Inappropriate emotional behavior

   h. High rates of sterotyped, repetitive behavior.

   i. Bizarre responses to various aspects of the environment; resistance to change, peculiar interest or attachments to animate or inanimate objects.

   j. Isolated areas of high level functioning in the context of otherwise low level intellectual functioning.

   k. Delays in cognitive functioning.

6. Parents must be willing to participate and work in conjunction with parent trainers in a home follow-up program including the areas of behavior, language, socialization, self care, academics, and pre-vocation.

If this criteria is not met, the M-team must decide if this placement or another is more appropriate.

EMOTIONALLY DISTURBED

Emotionally disturbed students are served in a program with two components. The mildly to moderately disturbed students are being served in the Program for Emotionally Disturbed and the moderate to severe in the Treat Program.

PROGRAM FOR EMOTIONALLY DISTURBED

Youngsters from ages 4 to 22 are served in this day school program, though seldom are students younger than six years of age or older than nineteen, enrolled.

Comprehensive services which encompass academics, guidance and psychological counseling are provided during the school day. In addition to the teacher, a mental health team which consists of a psychological services worker, a psychometrist and a school social worker, is assigned to each class for emotionally disturbed. The team provides supportive help to the student and to parents.

Students may be served in a Comprehensive Development Class or in a resource class depending on the needs of the individual.

The curriculum taught in the Comprehensive Development Class is as close to the "regular" curriculum as possible. Each child has an individualized education plan which focuses primarily on behavior control, socialization skills and academics.

In the resource class, individual needs may vary from the support for behavior/emotional problems to the need for academic support. These students are programmed individually with their abilities and disabilities being considered.

Behavior management is a vital part of the program, with behavioral goals set by the students, (under the guidance of the teacher) each morning and then evaluated by them each afternoon. The reinforcement schedule varies with the individual, however there is a weekly goal trip which any student may earn. This in-community activity is a strong reinforcer and aids in the development of social skills.

The students may return to the regular classroom when the problems are sufficiently under control. The return is carefully orchestrated, with the student gradually returning one subject area at a time rather than being moved from full time Comprehensive Development Class placement to full time regular classroom placement.

Ten students in an emotionally disturbed classroom with a teacher and an aide receive no homework. It is our belief that after a day of intensive academic and behavior controls, the student and parents deserve to have as little stress as possible in the home situation. Students need to have the freedom to enjoy leisure time activities and parents deserve to be able to enjoy their child. Parents and the student continue to monitor behavior but with no academic involvement. This policy is a relief to both parents and students. However, as the student progresses and a return to the regular classroom is eminent then homework may be assigned, but only in small increments. The parents are asked to provide a quiet time and place but otherwise to remain uninvolved with homework.

Parents and professional staff work very closely together to assure a quality program for the emotionally disturbed student in Memphis City Schools.

The TREAT Program

Carol Randalls

Since the early 1970's, the Treat Program has represented a successful cooperative effort between the Memphis City Schools and a state mental health agency, Sequoyah Center.

The program serves emotionally disturbed students ranging in age from six to about 14 who could benefit from an intense extended day experience. This includes students returning from state or private residential programs, students attempting to avert future placement in a residential setting, as well as any student who needs more than the traditional seven hour self-contained emotionally disturbed class.

The city schools portion of Treat consists of three classrooms, each with a teacher, a teacher's aide and 8-10 students. The student is assessed into the program after a psychological report has verified his emotional problems and an M-team consisting of parents and at least two professionals agree that Treat is the most appropriate placement.

The child is then placed in one of the three classrooms, depending on age, abilities, and greatest needs.

Since children with behavior disorders have often experienced academic frustration and/or failure, each child is tested as he enters the program, and an individualized education plan is written so that each lesson is designed to meet his needs at his level. Just offering the child material on his grade level frequently produces wondrous results; it may be the first passing grade he's encountered!

Academic success and achievement are important goals, but they are generally achieved in conjunction with or through the primary goals of Treat: helping the student manage his behavior, and improving his self concept and chances of success by teaching him that he does have control over his actions, that he can function properly in a classroom environment, and he has a right to achieve these goals. Many of our students have never had an opportunity to learn that they, too, possess desirable characteristics: leadership, scholarship, dependability or just the chance to be labeled a "good" kid.

These goals are achieved through the use of a structured (though not inflexible) behavior management system. At the beginning of the week, each student (with the aid of his teacher and peers) sets a realistic, attainable behavioral goal for himself. These could range from "I will speak to at least three people daily" for the withdrawn child to "I will avoid hitting when angry" for the aggressive child - "I will stay on task" for the overactive child to "I will be a leader" for the student anticipating return to a regular classroom setting.

The goals are discussed among the class, and group support for each child's success is emphasized. The goals are periodically reviewed during and at the conclusion of each day.

Further, each teacher emphasizes a basic set of desirable behaviors that all students should demonstrate throughout the day. These behaviors (such as following directions, getting along with others, etc.) are discussed and evaluated at regular intervals.

The emphasis is on the positive here, with "catch the child being good" as a major theme in each class. A child is often, for example, sent to the office as reward rather than punishment. Other methods for reinforcing desired behaviors include recording successes on classroom charts for future rewards, verbal praise, physical contact, notes and awards presented in class and sent home, points or merits to be traded in for earned items or activities, and the opportunity to earn weekly goal trips.

At the end of each academic day, the student's achievements are discussed during "Pow-Wow" sessions. Here each child is encouraged to evaluate his own strengths and weaknesses. Comments from his peers are welcomed, and while criticism and suggestions are a part of the Pow-Wow session, they too are done in a helpful, positive manner.

Often it is not the other students or the teacher who is critical of a student, but the child who is too critical of himself. Treat teachers use the Pow-Wow session as an opportunity to teach the child with a poor self concept to discover that he had done certain things well that day, even if the day hasn't been all he hoped for.

The Pow-Wow session is also a time for a child to learn to acknowledge his mistakes, errors in judgment, or lack of self control. This is a difficult lesson for many, but once a problem is acknowledged, methods for avoiding such problems in the future are presented.

At the end of each week, an evaluation is sent home detailing the student's areas of accomplishments as well as areas that need improvement. If the child has achieved a pre-determined number of points (depending on behavior and success in achieving his goal) he may earn Friday's goal trip. This may range from a snack in the classroom to a special art project, or to a visit to various places in the community. If a student does not earn the weekly trip, reasons are discussed and often that child's required number of points will be altered to a more achieveable level for the following week.

Other behavioral techniques employed in the Treat Program are peer support in both academic and social endeavors, individual or small group teaching for the child who benefits most, group teaching to prepare the child for re-entry to regular class, isolation from group or short "time-out" periods for the child who needs to regain control, acceptance of individual needs and differences, and encouragement of self expression.

The afternoon portion of the Treat student's day begins (after 5 hours in the city school class) with a bus ride to Sequoyah Center. The 3 classes are divided into two groups with the emphasis here on group interaction, arts, P.E. (including weekly swimming), and knowledge of the community. The city teachers provide support for the afternoon program, just as the Sequoyah teachers often assist in the morning.

Our goal for every child is return to a less restrictive classroom setting. When a child has seen continued success in Treat, teachers begin to prepare him for a gradual shift to a more appropriate program. After phasing him cautiously out of Treat, we know we've attained our goal when the student begins to refer to someone else as "my teacher" and another as "my class." Many return full-time to regular class with continued success.

Raineswood Residential Center
Division of Special Education
Memphis City Schools:

How We Do It

Carol McKinney

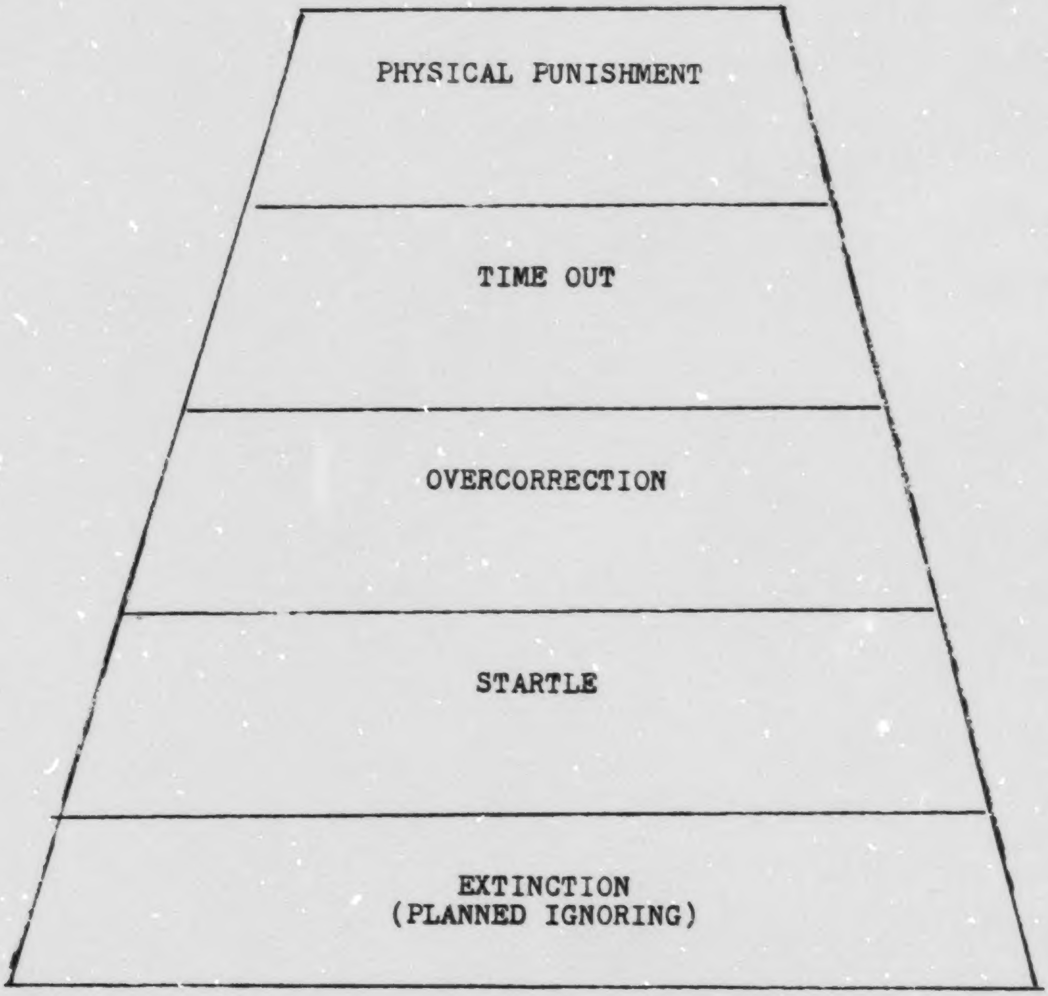
"Ninety-five percent of all autistic adults end up living in institutions and often in the back wards"--but this does not have to happen. The facet of our program that makes it unique is that we use behavior modification extensively and successfully throughout our program to eliminate the bizarre, aggressive and other anti-social behaviors which are associated with autism.

When a student first comes into our program, the most anti-social behaviors are pin-pointed and these behaviors are base-lined for one week. Also, an informal observation notebook follows the student from program to program to give all persons involved with the student an overall picture of his behavior throughout the day. By doing this we gain much helpful information such as his likes and dislikes, strengths and weaknesses, and reactions to various situations.

Next we meet to "staff" the child and write--and often rewrite--behavior programs on the target behaviors. We try to keep the number of behavior programs on any one student to three or four of the most disruptive and anti-social behaviors present at the time. Data is kept on each target behavior. This helps us to monitor the child's behavior and indicates whether our behavior programs are being effective.

For each negative behavior to be decreased, in addition to the aversive consequence for the occurrence of this behavior, we include a positive component. We state the behavior that we want to increase and the manner in which the student is to be rewarded. We strive to insure that positive reinforcement of appropriate and desired behaviors is the focal point of our behavior management program.

The "Punishment Ladder" (see following page) illustrates the aversives that we use. We always start with the least aversive technique and move up the ladder in trying to eliminate an inappropriate behavior. Most of the following descriptions of the steps on the ladder have been taken from the Raineswood Center's Training Manual for Para-Professionals (Memphis City Schools, 1981).


PHYSICAL PUNISHMENT
TIME OUT
OVERCORRECTION
STARTLE
EXTINCTION
(PLANNED IGNORING)

THE PUNISHMENT LADDER

(With permission of the Utah Program for Autistic Children. Parent Involvement Program: Parent Manual. U.S. Dept. of Education/Office of Special Education)

I. POSITIVE REINFORCEMENT

Positive reinforcement of appropriate and desired behaviors is a focal point of our behavior management program. The Law of Reinforcement states that any behavior that is followed by a reward will increase in frequency, and those behaviors not rewarded tend to decrease. Rewards may be tangible or "primary" (food) or social (praise, hugs, etc.). They are initially given with each occurrence of the desired behavior and later given intermittently. Intermittent reinforcement of an established desired behavior is the most powerful way of maintaining that behavior.

Behavior shaping is approached in a systematic, common sense way. After deciding which behaviors are desired to be increased or decreased, a step by step sequence is planned assuring success and achievement for the child. The first step in such a sequence is planned so that the child will experience success very quickly. In this way, it is insured that the programs are inadvertently positive. Each successfully completed step in the sequence is rewarded and the child's inappropriate behavior is slowly reshaped into desirable behavior.

As the child becomes more competent in performing the targeted behavior, the use of primary (edible) reinforcers is decreased and social reinforcers (praise) become the principal method of rewarding the child. In this way, the child is acclimated to the types of rewards more commonly used in the school and community.

Some Types of Positive Reinforcement

A. Positive Practice

Anytime punishment is used to decrease a defined problem behavior, reinforcement of an incompatible, more appropriate behavior is also part of the treatment. If we do not provide the child with an appropriate substitute, we see what may be called "symptom substitution", whereby the targeted behavior disappears but is replaced by another inappropriate behavior. Positive practice is a way of teaching a child what to do, rather than what not to do. For example, for a child with toileting problems, anytime an accident occurs, the child is not simply over-corrected but taken through the appropriate, desired toileting procedure several times ("positive practice"). This technique is readily applied to many undesirable behaviors a child may exhibit.

B. Peer Modeling

As a child becomes more aware of his environment and those around him, he begins to notice what behaviors in other students are rewarded and punished. In other words, a child's peers are also an excellent vehicle for teaching appropriate behavior. If a given child is exhibiting an inappropriate behavior, all others in his presence may be rewarded for appropriate behavior we want the child to learn. If, for example, one student is screaming or making undesirable noises in an effort to gain our attention, one would reward all the other children present for being quiet. A treat may be given to each child who is behaving appropriately while praising the children for quiet behavior depending on the level of the child in question. Note: Verbal and social praise are always paired with primary reinforcements so that as edibles are removed, the association with social rewards is already built in.

C. Token Economy

As students learn to delay gratification for good behavior for longer periods of time, more sophisticated methods of behavior management are begun. One such method is the Merit-Demerit Program. In this program an index card is given to the child each morning, one half of which is designated for "merits", the other half of which is for "demerits". Positive behaviors to be increased are rewarded by (+), while inappropriate behaviors to be decreased are punished by a demerit (x). At the end of the day (after showers), or at the spontaneous request of the student, merits may be traded in for money (2 merits = 1¢), favored activities or edibles. Each child's merit program reward system is tailored to his or her individual needs and preferences. The number of merits earned is determined by subtracting the demerits from the merits. If the child has more demerits at the end of the day, an appropriate, individualized punishment is carried out. One great advantage of this program is the flexibility it provides in dealing with a wide range of subtle desirable and undesirable behaviors. Children learn the responsibility of keeping up with something of value to them, and the use of the card easily transfers to learning money concepts. As students are phased out of the residential setting and into other classrooms or workshops, the merit program also provides a bridge for behavior control to other professionals.

II. PLANNED IGNORING

Often times a student has learned a minor inappropriate behavior that he/she knows will get the attention and a response from the teacher/trainer. These minor inappropriate behaviors are called attention seeking behaviors and include whimpering, animal-like noises, hand posturing, giggling, etc. They are minor mis-behaviors and are usually used by the student to get attention either in a positive or negative way.

The first step used in an attempt to eliminate the undesired behavior is to praise the child each time he/she displays an appropriate behavior. It is hoped that by gaining attention for good behavior the student will be motivated to be "good" the majority of the time. Thus, it is important to praise the correct behavior to reinforce that behavior so the student wants to behave correctly.

For each time the student does attempt to seek attention by using one of the attention getting devices, the planned ignoring program should be implemented. Planned ignoring calls for a completed withdrawal of all attention from the student. This should be accomplished in a rather matter-of fact manner with no visual or auditory cues that you as the teacher/trainer are upset or affected by the behavior. You should try not to show emotion. Withdraw eye contact by turning your head in the opposite direction of the student.

Once the student regains his/her composure and starts demonstrating correct responses, re-establish your contact with the student and remember to praise the student for responding and behaving appropriately.

Remember to "keep cool" and not to display any form of reaction to the behavior, simply withdraw your attention from the child.

On the second rung of the punishment ladder is a technique called "startle." To startle a student use a sudden loud noise or flash of light. A startle is not intended to harm a child nor to cause discomfort but is intended to surprise the child so that the inappropriate behavior ceases immediately.

The next technique is over-correction, which involves more than just putting the environment back the way it was before it was disrupted. As in planned ignoring, avoid anything which may result in the over-correction situation being rewarding to the child.

III. OVERCORRECTION/RESTITUTION

Rationale for use: To give the child responsibility for his disruptive or aggressive behavior by having him correct and over correct his disruption. It not only teaches the child what he did wrong, but also, a correct behavior.

Procedure for disruptions (marking on walls or furniture, spilling food, toilet accidents, tearing up paper, throwing toys, spitting, etc.).

1. After a disruptive behavior occurs, implement any time out procedure that is appropriate first. After the time out, begin the overcorrection.

2. Show the child what he had done and tell him he must clean it up.

3. Help him get necessary cleaning supplies together, such as a wet cloth, etc. Tell him to begin. Allow the child time to begin the clean up by himself. Do not talk to or coax the child. If he does not begin by himself, manually guide him with as little assistance on your part as possible.

4. He should not only correct his error, but overcorrect it. For instance, if he marked on a table, he should clean up the marks first, then clean the entire table. Over correction should last for 45 minutes, or until the student reaches a point of frustration.

5. If the child is resistive, wait until he is calm, then begin again. If the child exhibits any aggressive behaviors for which you have a program such as time out, implement that program and then return to the overcorrection.

6. Important: Remember that this is a nonreinforcing situation, so do not talk with the child or make eye contact. He probably will test limits by laughing, resisting or other means. All of these behaviors should be ignored. Do not reinforce the child for doing a good job of cleaning. This is a corrective procedure. Reinforce the child at other times when he is not being disruptive.

7. All toilet accidents should be thoroughly cleaned up, then clothing and/or bed clothing is placed in a plastic bag, and taken to laundry room by the child.

8. When the overcorrection procedure has been completed, have the child return to his regular activities.

9. Record the number of overcorrections on charts or in aide's or teacher's log.

IV. TIME OUT

Rationale for use: To remove the child from all reinforcement after the occurrence of a predetermined inappropriate behavior. To decrease or eliminate that behavior.

Procedure:

1. Begin the time out as soon as the behavior occurs or when the child is in the act of exhibiting the inappropriate behavior.
2. Stop the behavior by telling the child "No" or indicate what the child is doing, such as "No, you do not ______________."
3. Do not scold, or fight with the child. Take him by the arm and lead him to the place he is to time out.
4. If he resists, ask for help. Do not coax or talk to the child in any way. Also, do not make eye contact. Remain as neutral as possible.
5. If the child lies down on the floor, have someone assist you in pulling him up and taking him to the place where he is to time out.
6. There are three kinds of time out.
    A. Chair time out-
        1. Sit the child in the chair and turn the chair so that it is facing the wall or preferably in the corner. This way the child will not be able to make eye contact or talk with anyone.
        2. Sit the child down and tell him "You must sit quietly, and look at the wall."
        3. If the child refuses to sit, cross his arms across his chest and hold from behind until he is sitting quietly.
    B. Head down time out-
        1. In a head down time out, the child must put his head down between his legs and arms behind back. Sometimes an individual program may indicate a head down time out on floor with child sitting "Indian style".
        2. When this technique is first used on a child, it may be necessary to physically manipulate child into this position. If this is necessary, the child should hold position alone as soon as possible.
        3. Keep in mind that one of the goals of this procedure is to have the child go into this position on verbal command and regain control. ie. "You do not ____________." "You need to time out."

7. Individual programs will distinguish the amount of time the child must remain in head down time out position. If you have held the child, he beginsto sit quietly and you release the child to start the timer and the child attempts to get up again, stop the timer and put the child back in the time out position and hold until he is sitting quietly again.

8. Do Not start the time until the child is sitting quietly. Then say "You are sitting quietly so I will start the timer."

9. On first occurrence of any disruptive behavior (head turning, noises, hand/feet movement, rocking, slumping) after timer has started, stop the timer and say the most appropriate statement. ie.
   "I have to start the timer over."
   "You must be quiet"
   "You must keep your head down"
   "You must look at the wall" etc.

10. Wait until the child is sitting correctly before starting the timer again. Repeat steps until the child sits for number of minutes designated on individual programs.

11. When the time out is over, simply tell the child he must get up. Then return him to his previous activities or implement any appropriate restitution. If the child will not get up, walk away and leave him until he decides to get up. Never try to coax or pull the child out of the chair.

12. After time out, child should say or sign "I am sorry, I will be good."

13. Time out should be repeated for every occurrence of the inappropriate behavior.

14. A positive reinforcement program for appropriate behaviors should always be used in conjunction with the time out program.

C. Room Time Out-

When a student displays inappropriate night-time, bed-time behavior, a room time out program may be implemented. The program should be used in its progressive sequence to help the student know just what you expect of him/her.

First, let's remember to make preparation for bed and bedtime as pleasant as possible. This can be achieved by taking those extra minutes to tuck the student in bed, listen to their prayers, review the good things the student has accomplished that day, telling him/her a bed time story, or just sitting on the bed holding his/her hand and telling them it is time to sleep. If the child has brought a favorite toy or stuffed animal, etc. tuck it in bed with them to give them a feeling of security. After all, haven't we all experienced some difficulty sleeping in a strange environment? For students, residential placement is a major transition and should be approached with tender loving care.

If the child has gotten up out of bed after the lights have been turned off, immediately take the student by the hand back to the bedroom. Try to find out what the student may be trying to communicate by asking if he/she needs to use the restroom, wants water, etc. After checking all these items, tuck the student back in bed and tell them that "it is time to go to sleep."

If the student should wander out of the bedroom again, it is time for stronger course of intervention. This time, take the student by the hand and very firmly tell him/her that you do not want him/her to leave the room again. Place the student back in bed and tell him/her to stay there.

If the child continues to get out of the bed, this calls for the room time out program. You lead the child back to the room and tell him/her that since he/she did not stay in bed as instructed you will have to shut the door. You may have to secure the bathroom door of the adjoining bedroom to prevent the student from leaving the room through the bathroom. After you have placed the student back in bed, shut the door to the room. Do not lock the door since that would violate safety regulations.

Once you have shut the door, you need to position yourself in the hallway so you can listen for any behaviors that may be dangerous to the student, like tapping on the glass, opening the window, or throwing things around the room, etc. If these behaviors occur, you need to use discretion and deal with the behavior in the appropriate manner. Always discuss such events with the staff so, if needed, we can write a specific individualized intervention program.

Also, remember when a child is in a room time out situation stay in the hallway until the student is asleep. If it is going to be a long wait, share the responsibility of sitting in the hallway with the other staff on duty.

IV. QUIET TRAINING

Quiet training is a behavior management technique that requires a student to lie prone, face down, place his/her hands behind his/her back and be physically restrained by the teacher/trainer, limiting any dangerous movements the students may demonstrate (i.e. headbanging, biting, kicking, or scratching) until the student has regained his/her composure. This method is thought to be the most involved and most intense strategy employed by our staff.

Currently, quiet training as a behavior management technique is employed to control behavior on two occasions. One occasion when quiet training is employed is as a final resort to suppresss escalating disruptive behavior. The other occasion that it is used is to defend one's self or the other students from a physical confrontation of a student.

During the first occasion, quiet training is used only after a prescribed intervetion method has been implemented with no success, and the student is building up frustration and opposition. The student should then be quiet trained to regain his/her composure. Since quiet training requires a great amount of physical restraint and contact, it should be used after, and only after, the prescribed intervention techniques have been attempted.

Please keep in mind that the end result of quiet training is for the student to regain his/her composure by remaining calm and quiet on the floor without the use of restraint for a short period of time and until the student is responding appropriately to verbal commands. This period of a calm state may take several attempts of fading restraints then reapplying restraints because the student is not composed enough to lie on the floor quietly and calmly. Once you have determined that the student is in control of him/herself, return to task. He/she should be allowed to carry on with the normal routine of the day.

Remember that it will be more difficult to restrain the student a second time if he/she is not in control when allowed to return to task the first time. Common sense, good judgment and experience are key factors in the effectiveness of quiet training.

In the second occasion, a student has lost his/her temper and tries to physically hurt other staff or students. In this case, the student is immediately quiet trained until he/she responds appropriately to verbal prompts and commands. Remember to keep the student from hurting himself/herself during this tantrum.

In both cases, the student should be required to say, "I'm sorry", in whatever avenue of communication he/she utilized to all parties involved and make restitution for any breakages or messes he/she makes during tantrum. Once the quiet training session is over, the student is allowed to carry on with the regular routine of his/her day.

V. PHYSICAL PUNISHMENT (SPANKING)

The most aversive and least often used technique is physical punishment. Spanking is not outlawed in behavior modification, but it is one of the last punishments used, when everything else has failed. The child should be verbally reprimanded ("No, you do not ______________".) and be given a quick spank or "swat" with the hand. In some cases a quick spank with a ruler on the palm of the hand is used. Individual programs will distinguish the type of spanking to be used. The "spank" should be severe enough that he reacts to the punishment, but not so severe as to hurt him physically, such as bruising. Spanking is only done by teachers, not aides. In some cases it is extremely effective, working when everything else has failed.

***

It might be fitting to end with one of the Center's success stories. Michael is 22 years old. He came to the program about three years ago. His parents and teachers had "had it" and were considering placing him in an institution. He was aggressive, would eat only Spaghetti-O's, made paper ball, wouldn't get his hair wet in the shower without a tantrum--and still won't tie his shoes, but he now wears loafers.

He now has excellent self-help skills, including washing his hair. Over-correction eliminated the paper ball habit. He has excellent leisure skills and will eat almost any food. He loves to go into the community. He hasn't had a tantrum or been aggressive in over a year, and is definitely a candidate for a group home when he graduates from the special education program this spring. Michael is what our program is all about.

Meeting the Needs of Autistic Individuals in a Comprehensive Community-Based Service Provider for the Developmentally Disabled

Daniel B. Rosen, Executive Director,
Bost Human Development Services
Rose A. Adams
Nancy Rogers
Rusty Sheridan
Jay Whitsitt

SUMMARY: Bost Human Development Services, Arkansas' largest and most comprehensive community based service provider to the mentally retarded and developmentally disabled, has undergone a transition over the last several years from an agency providing only educational services to mentally retarded school-age children to a comprehensive provider (educational; residential; vocational) for all ages and types of developmental disabilities (mental retardation; cerebral palsy; autism, etc.).

The paper will present the experiences of an agency undergoing change and how these changes have been eventuated, even in the face of a constricting economy.

Particular emphasis will be placed on unique programs, emphasizing an educational service for autistic/autistic-like individuals.

Issues addressed will include: methodology, program design (especially innovative techniques), and the use and interfacing of numerous funding sources, including private philanthropy.

Administrative as well as operational concerns will be discussed.

Slides and written documentation will be provided.

Remarks of Daniel B. Rosen

I. Overview of Bost Human Development Services
   - History/Current Status/Future

II. Slide presentation on Bost Human Development Services

III. Discussion of Funding and Concerns regarding interfacing these services with other agency programs.

Remarks of Rose A. Adams

Administration/Program Planning

Every new program requires planning and preparation before actually beginning operation. BHDS spent almost 1½ years in preparation before beginning its program for individuals with autism. (Appendix **A** is a sample of considerations in planning a program of this type.)

BHDS began operating the program in August of 1982. Previously there had been no services in Fort Smith, Arkansas, or in the surrounding area which specifically addressed educational programming for individuals with autism. Obviously, there were people with autism, but they were primarily identified as mentally retarded or severely emotionally disturbed. When BHDS began its program, four such individuals (ages 6-13) were enrolled in it. (Evaluation and identification of individuals with autism continues to be a problem for the program. BHDS does not currently perform this function but instead must rely on public school examiners, local psychologists, and medical personnel. Finding professionals locally who are both qualified and willing to make the diagnosis of autism has indeed been a discouraging task.)

The commitment by the overall agency to providing quality services to individuals with autism quickly grew. Two staff members (a speech pathologist/teacher and a teacher's aide) volunteered to work in the program.

The next stage of planning was to estimate the cost of the program and to find funding sources for it. The students enrolled would be provided services under contract with the local public schools. Initial staff training was at minimal cost due to a cooperative arrangement between agencies. Facility modifications (including building an observation room between two small classrooms), additional staff training, and a collection of books and manuals were underwritten by a local service organization. A private trust fund provided BHDS with a video taping system. BHDS already had on hand many materials and pieces of equipment which could be utilized or easily modified for use by the students enrolled in the program.

Next came the process of general research and resource building, staff training, and evolution of the agency's philosophy regarding educational programming for individuals with autism. NSAC and ASAC, Arkansas' state chapter, were both extremely informative and proved to be good initial points of reference for further research. (See Appendix **A** for additional references/resources.) Two BHDS staff members were trained at Ouachita Regional Counseling and Mental Health Center in Hot Springs, Arkansas (a Judevine Center for Autistic Children). This training site was selected because of its proximity to BHDS and because it was an experienced center. It provided good, low-cost training close to home which was a definite consideration for BHDS for the initial year of operation of the program.

Although initial training was in Judevine methods, BHDS has attempted to develop a more eclectic approach in programming for individuals with autism. The attempt has been to provide a humanistic and functional program for each individual within a developmental framework while utilizing behavior management techniques, not only in the school environment, but at home and in the community, as well.

The program at BHDS functions as a "resource room". Students in the program are assigned to a home classroom where they spend a portion of the day in a group setting and then are scheduled into the resource room or specialty areas (e.g., speech therapy, homeliving, motor development) for 1:1 or 1:2 work throughout the course of the day. Consistent methods of behavior management are used by all staff members who work with the individual student.

Parents are encouraged to take an active role in following through with training for their children while at home. BHDS staff are available for consultation, and conferences are held periodically to share information and to review each individual's progress.

Individual progress is monitored by collecting written data on occurrence of targeted behaviors and on performance related to goals/objectives of the student's IEP. Videotaping is also used intermittently to document progress and to target specific behaviors and behavior chains.

The need to assess and document each individual's progress and behavior is vital to providing functional, relevant, age-appropriate, quality, goal-oriented training for that individual. It is perhaps equally important to assess and document the program's progress.

One of the best ways to document the program's success is by documenting each individual's success within the program. Another measure may be the cost-effectiveness of the program. Staff attrition might be an indicator. Subjective measures such as parents' and the community's perceptions of the program might also be helpful in program evaluation.

BHDS has achieved a degree of success in its program for the first year, largely as measured by the progress of individual students in their IEP's and behavior programs. However, several areas need improvement and will be addressed during the second year.

Primarily, individual programs need to be made more functional and age-appropriate. As the curriculum evolves, staff will need updated training in writing more practical IEP goals/objectives and in using more practical materials and teaching methodologies. More extensive parent training is needed. A more concise and consistent data collection system needs to be developed for use by all staff who work with the individual to provide a more accurate picture of individual and programmatic success.

Remarks of Jay Whitsitt

I'm Jay Whitsitt, an aide in the resource room for autistic and autistic-like students. As you are going to see in the following videotapes, I work with the clients on a 1:1 basis except in the afternoons when I have small group sessions.

My students are pulled from their homeroom at least once daily, most days two times a day.

Each student has a 30-minute session with me. Before beginning my session I require good in seat behavior, hands down, which means the hands are not busy with inappropriate actions, and attending to me upon request. If a client cannot comply with these requirements then he/she is taken through compliance training using food exchange techniques. Every time the client complies to the request of "hands down, look at me," he/she is given a bite of food. As you will see on the monitor the command had to be modified for one of the clients and she was asked to comply to only one command at a time. Criteria was 80% compliance for two weeks. Then we moved to the next command. After compliance different tasks were introduced for the client to master.

With the other clients you will see I teach a lot of academic skills. They include reading readiness skills, pre-math skills, fine motor skills, visual and oral perception, functional skills and oral language.

Remarks of Rusty Sheridan

The speech and language sessions for the autistic clients are set up on a one-to-one basis, with each client receiving 30 minutes of therapy each school day.

The sessions are developed using the principle of beginning each session with a "liked" activity and when the client's interest in the activity is greatest, the activity is changed, quickly, to one that the client does not like to do. Contingencies are used during the disliked activities as a method of reinforcement. Each activity, such as pointing to pictures upon request, do not last more than five minutes so as not to cause frustration, undesirable behaviors, or boredom. Then another liked activity is presented.

During the therapy sessions, literal meanings are used. For example, a client may be asked to point to the picture of the shoes if a picture and not the real object is presented. All staff members, parents, siblings, and anyone coming in contact with a client are instructed as to how to give requests, how to use contingencies and any other necessary information concerning that client.

(Video tapes were shown to demonstrate the techniques and revisions to some techniques used at BHDS.)

One technique that is used in language therapy sessions is to ignore any inappropriate behaviors and to give quick verbal praise as soon as that behavior stops. Instead of using "time-out" on the client this technique of ignoring or "instant teacher time-out" (looking away and whistling, reading, etc.) has been the most effective deterrent of undesirable behaviors for the autistic population at BHDS.

Remarks of Nancy Rogers

My class is homeroom for eleven students ranging in age from nine to fifteen. Three of the students are autistic and eight are mentally retarded. Four of the students are non-verbal, three have Down's Syndrome, one has Cornelia deLane Syndrome; two function in the mild range of retardation, five function in moderate range of retardation, and four function in the severe/profound range of retardation.

Each year an Individual Education Plan (IEP) is written specifically for each student. The IEP contains individual goals written in coordination with various specialists for each client. According to the IEP each student attends various classes. These classes include homeliving, speech, autistic resource, and motor development. One student has a special motor development class designed in coordination with an occupational therapist. We incorporate the skills taught in the other classes as much as possible. For example, the use of a language board from speech class.

In addition to IEP goals my students work on other activities. While I am working with a student on his goal work, the classroom aide assists the class on activities such as writing names, numbers, letters, and other fine motor tasks. We also work on auditory and visual perception, fine and gross motor skills. All of the students vary in their abilities to do each of the skill areas named above.

The autistic clients have been a pleasure to have in my class. They have worked well with the other students. Occasionally there is an outburst. When this happens we try to get the student back on task as soon as possible. If we are not able to calm the client, we send him to the autistic resource room with his task that must be completed before returning to class.

APPENDIX A

A SAMPLE OF CONSIDERATIONS IN PLANNING AND IMPLEMENTING A COMMUNITY-BASED DAY PROGRAM FOR INDIVIDUALS WITH AUTISM

NEEDS ASSESSMENT/IDENTIFYING INDIVIDUALS TO BE SERVED

Is there a need for a day program for individuals with autism in or around your community? How many individuals have been identified as possibly needing these services? How do these individuals range in age, functioning levels, and severity of autism?

What is the optimal number of individuals whom your agency could serve? What age range of individuals would be served? What minimum level of functioning would be required of individuals for admission? Would individuals with aggressive behaviors be admitted?

Possible Resources: (needs assessment/identification)
- local school and day care personnel
- service providers to mentally retarded persons
- local pediatricians/family practitioners
- state department of education
- local social service agencies

AGENCY AND STAFF COMMITMENT

Is the agency really committed to providing quality services to individuals with autism?

Would the staff really be committed to and capable of providing quality services to individuals with autism? Which staff members would work with these individuals? Do they already have training and/or experience appropriate to working with individuals with autism? Would it be necessary to hire new staff members?

Possible Resources: (certification/licensing requirements)
- state department of education
- state department of developmental disabilities services

COSTS/FUNDING SOURCES

What would it cost to provide services to individuals with autism? What facility modifications, new equipment and supplies, training and/or hiring of staff, and other costs might be required?

Would current funding sources fund at greater levels for expansion of services? What new or supplemental funding sources might be available?

Possible Resources: (funding)
- current funding sources
- local public school districts
- State Department of Education
- state department of developmental disabilities services
- state and federal granting agencies
- local service organizations
- philanthropic organizations/trusts

GENERAL RESEARCH AND RESOURCE BUILDING

What is autism? What training/treatment methods are utilized with individuals with autism? What is involved in evaluation, assessment, and programming? What resources or authorities in the field exist?

Possible Resources: (general references/bibliographies/professional contacts)

- NSAC, National Society for Children and Adults with Autism
  1234 Massachusetts Ave. NW
  Washington, DC 20005
- state chapter of NSAC
- State Department of Education
- State Department for Developmental Disabilities Services
- Division TEACCH
  214 Medical School
  Wing B, 207 H
  University of North Carolina
  Chapel Hill, NC 27514
- Judevine Center for Autistic Children
  9455 Rott Road
  St. Louis, MO 63127
- Institute for Child Behavior Research
  4157 Adams Avenue
  San Diego, CA 92116
- Neurobehavioral Center
  1136 Alpine #210
  Medical Arts Clinic
  Boulder, CO 80302

STAFF TRAINING

Who will be trained? How and by whom? What provisions will be made for training support staff and volunteers? What staff/student ratio will be required?

Possible Resources: (personnel training)

- NSAC
- Division TEACCH
- Judevine Center for Autistic Children

(personnel requirements)

- State Department of Education
- state department for Developmental Disabilities Services

PHILOSOPHY

What is the agency's philosophy in programming for individuals with autism? Would a developmental model be used? What areas of training would have priority? How much emphasis would be placed on behavior management? Will aversive stimuli be utilized? How would it be monitored? What role would parents play in training their children?

Possible Resources: (general references/recommended reading)
- NSAC

(relevant regulations)
- P.L. 94-142
- state department of education
- state department for developmental disabilities services

FACILITY MODIFICATION/CONSTRUCTION

What is a suitable environment for training individuals with autism? What are the space requirements? What is necessary to comply with licensing requirements and building codes?

Would there be an observation room? Could videotaping be done inconspicuously?

Possible Resources: (environmental requirements)
- NSAC
- state and local building codes
- state department of education
- state department for developmental disabilities services

EQUIPMENT AND SUPPLIES

What specialized and/or additional equipment and supplies would be necessary for training individuals with autism? Is a videotaping system necessary? Would the materials be age-appropriate and practical? Could the equipment and materials be used with more than one individual?

Possible Resources: (equipment and materials)
- creativity of the staff
- parents of individuals in the program
- other existing programs for individuals with autism
- state department of education
- state department for developmental disabilities services

EVALUATION AND ASSESSMENT

Would the evaluation and assessment be utilized for service eligibility as well as for individual programming? Who would do the evaluation and assessment? What instruments would be used? Would a medical diagnosis be required?

Possible Resources: (information on evaluation and assessment/medical aspects)
- NSAC
- state chapter of NSAC
- Division TEACCH -- (PEP/CARS)
- state department of education
- state department for developmental disabilities services
- other existing programs for individuals with autism

PROGRAMMING/SCHEDULING

Would a packaged curriculum be appropriate for training individuals with autism? What modifications/adaptations would it be necessary to make?

How would class assignments and scheduling be determined? Would therapists/specialists work with the individuals outside the classroom or within the classroom?

What training priorities would be established for the individuals? Are the tasks age-appropriate? What teaching methods will be used? Would parallel teaching be utilized? How much and what types of behavior management would be required? How would the individual's program fit into the agency's overall program?

Possible Resources: (programming recommendations)
- NSAC
- Division TEACCH
- Judevine Center for Autistic Children
- state department of education
- state department for developmental disabilities services
- creativity of the staff

PARENT TRAINING/PARENT INVOLVEMENT

What role should parents take in training their children? What skills do parents need to train and manage their children?

How should parents be trained? What format would be used? Who would do the training? How would the training be scheduled? How could the agency motivate parents to take an active role in training their children?

Possible Resources: (general recommendations/bibliographies)
- NSAC
- Division TEACCH
- Judevine Center for Autistic Children
- parents of individuals in the program
- other existing programs for individuals with autism

DATA COLLECTION

What data collection system will be utilized? Who would collect the data? For what purposes would the data be collected?

Possible Resources: (data collection techniques)
- Division TEACCH
- Judevine Center for Autistic Children
- state department of education
- state department for developmental disabilities services
- other existing programs for individuals with autism
- videotaping

ON-GOING TRAINING

What on-going training would be provided to staff, volunteers, and parents?

Possible Resources: (on-going training)
- NSAC conferences
- state chapters of NSAC conferences
- other related workshops and conferences
- inter-disciplinary staff meetings
- professional journals/library
- staff visits to other programs
- use of videotaping

CONTINUAL EVALUATION OF OVERALL PROGRAM/MODIFICATIONS

How would the success/failure of the overall program be evaluated? By whom? How often? What modifications might be necessary and/or beneficial?

To what extent have individuals progressed within the context of the overall program?

Possible Resources: (evaluation)
- state department of education
- state department for developmental disabilities services
- data on individual progress
- use of videotaping
- staff/parent feedback

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CHILD MENTAL HEALTH SERVICES, INC.

Betty Milner, Director
Allan Cott School

Child Mental Health Services, Inc. was founded in 1973 as a non-profit organization devoted to developing and implementing comprehensive services for schizophrenic, autistic, and emotionally disturbed individuals.

Allan Cott School was the first program of Child Mental Health Services, Inc. The school opened in September, 1974, and is a day school for schizophrenic, autistic, and severely disturbed children. The school serves individuals who can not be maintained in a public school program, but who can benefit from a structured learning environment that is designed specifically to meet their needs. We began with 16 children between the ages of 4 and 12, and have expanded to 50 children from ages 2 through 19. Allan Cott School contracts with seven local school agencies to provide educational services for this population.

Camp Sunshine South began in 1975 as the second program of Child Mental Health Services, Inc. The camp operated the first year as a day camp program for severely disturbed children.

From 1976-1979, the camp operated as a therapeutic, residential camp. The children admitted to the camp program participated in a recreational and educational program which was designed to teach skills such as swimming, hiking, crafts, boating, fishing, athletics, and other group games. The residential camp offered the severely disturbed child the opportunity to learn new skills, and at the same time provided a seven week respite time for the parents.

In 1980 and 1981, Child Mental Health Services, Inc. has operated a day camp at Mountain Brook Baptist Church. The day camp program operates Monday through Friday from 8:30 to 3:30. The day camp program has been carried out in place of the residential camping program due to the lack of an adequate residential camp facility. The day camp provides valuable services, and teaches some of the same skills that are taught in the residential, therapeutic camp; however, the activities are more restricted.

McDonough House is a part of the residential component of Child Mental Health Services, Inc. The McDonough House provides a residential, therapeutic, living situation for autistic, schizophrenic, and severely disturbed children. The children served at McDonough House are 6-21 years of age, and participate in the Allan Cott School program.

McDonough House is set up as a family unit. Two houseparents are in residence with six children. The home provides both a structured program that teaches independent daily living

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skills, and a supportive environment that offers as much as possible a family atmosphere. McDonough House has been in operation since March, 1980. The present home is located in a neighborhood setting in the Birmingham area.

Parkland Place is another component of the residential services provided by Child Mental Health Services, Inc. Parkland Place offers a supervised Apartment Living Program that provides a community residential program for young adults that have been diagnosed schizophrenic. The goal of Parkland Place is to help residents learn, through a structured program of classes, etc., to live successfully with their illness.

The program is housed in a six unit community-based apartment building. Two residents share a comfortably furnished two bedroom apartment, and one apartment is used for classes and staff who provide twenty-four hour supervision.

All residents participate in a structured schedule of daily activities including classes, exercise, meal planning and preparation, crafts, and various cultural and educational outings. The ultimate goal of the program is to teach residents to become a functional member of society who is capable of independent living and working with a very minimum amount of supervision.

The supervised apartment living complex is located in a community in Birmingham that is supportive of the purpose, and that is easily accessible to churches, stores, parks, transportation, and other community resources.

Admissions Procedure

Allan Cott School serves autistic, schizophrenic, and severely disturbed individuals between the ages of 2 and 21. Referrals come from local boards of education, speech and hearing clinics, mental health centers, and psychiatrists. The referral process involves:

1) Contact with local education agency responsible for student
2) Completion of application form
3) Psychiatric evaluation to determine primary diagnosis
4) Accumulation of previous evaluations (academic, language, hearing, psychological, occupational therapy)
5) Presentation to Admissions Committee

The Admissions Committee is composed of psychiatrists and representatives from local education and mental health agencies. This group determines the eligibility of the child by reviewing the information compiled with the application. The determination of the least restrictive environment for optimal learning and behavior change is equally important.

Child Mental Health Services, Inc.--Allan Cott School

Program Description

The philosophy of the Allan Cott School program is based on a biochemical orientation. Because of a brain chemistry dysfunction, these students are believed to suffer from perceptual disorientation which causes them to perceive the world in a disturbed manner. This perceptual disorientation involves auditory, visual and tactile stimuli - all the senses that we use to orient ourselves to the world around us. Input is not being properly processed, and this results in a bizarre perception of the environment.

Our task is to look at the ways in which our students relate to the people and objects around them; and then try to teach more appropriate responses. Presentation of stimuli in more than one way can take advantage of the senses that are functioning more effectively. An example of this is the use of sign language. It has been long felt that these individuals are not processing auditory input properly. Sign language is used to take advantage of the visual sense. The pairing of visual and auditory stimulation is an effective way to present information; and through this double barrel approach, the chances of the student understanding input is greatly improved.

Primary program emphasis centers on the following areas:

1) Behavioral - developing and implementing programs to deal with and decrease inappropriate and undesirable behaviors.

2) Communication - the establishment and increase of communication skills, whether verbal, sign, or symbolic.

3) Functional living - training in self-help, self-direction/ leisure time behavior, and home tasks.

4) Vocational - the teaching of appropriate work behaviors, and skill training in specific work related tasks.

5) Functional Academics - the adaptation of academic tasks into daily activities.

Treatment modalities encompass a wide range of therapeutic techniques. The basics of behavior management are refined and adapted to meet the individual needs of the students. Sensory stimulation activities are supervised and carried out by occupational therapists working with the classroom teacher. Movement and dance therapy is provided through the Creative Dance Foundation, which works with area schools. Much emphasis is placed on functioning, not only independently, but in small and large groups. Attention is paid to the coping skills of the students in different situations and under different kinds of stress. Language stimulation occurs continually through the day, utilizing a total communication system of signing paired with spoken language. For those students with already existing communication skills, comprehension and functional use of language is stressed. Vocational activities are incorporated into the daily school day. Younger students are involved in pre-vocational tasks such as sorting, assembly, and collating. Older students work on specific work tasks that produce a finished product. Functional living skills are stressed and much involvement with families occurs in training in this area. The acquisition of functional living skills will take some of the daily care responsibilities off the shoulders of the family.

Staff

The professional staff of Allan Cott consists of a Director, Special Education teachers, Speech Therapists, and Occupational Therapists. Each classroom has a head teacher and an assistant who work with from four to five students. Area colleges place students in special education, psychology, psychiatric nursing, and related mental health fields to work at the school for practicum experience. Additional volunteer help is provided through civic groups, high schools, and individuals wishing to involve themselves with this population of students.

Much importance is placed on hiring creative people who are continually evaluating and improving programs. Staffings are held three times a week, where the individual programs are discussed and revised. The sharing of ideas and concern for students goes to creating a stimulating, caring environment.

Parental Involvement

Parents are an important part of the program at Allan Cott School. Beginning with the writing and implementation of the IEP, family members are encouraged to visit the school and become a part of the educational process. Programs are designed to assist the family in coping with home behaviors.

The Allan Cott Parents' Association functions as a support and educational group, providing a place to discuss mutual concerns. They are also actively involved in fund raising projects, buying much needed equipment, raising camp scholarships, and participating in the annual Holiday Pecan Sale.

Residential

McDonough House is the residential component of Allan Cott School, providing a therapeutic living situation for autistic, schizophrenic and severely disturbed children and adolescents. McDonough House is set up as a family unit. Two houseparents are in residence with five to six children, ranging in age from six to eighteen. The make-up of the group is important; and careful attention is given to establishing a workable family unit. The age span provides a realistic situation of older children helping younger ones and more capable children helping the lower functioning. The goal of McDonough House is to provide a structured program in which the person may learn; but at the same time offering a "home" rather than an institution. A committee drawn from the Board of Directors of Child Mental Health Services, Inc. serves as an advisory group; setting policy as well as assisting in screening children applying to the McDonough House program. The initial application is reviewed by the Admissions Committee of Allan Cott School, with the McDonough House Committee then picking those children to enter the program when an opening becomes available.

The residents of McDonough House attend Allan Cott School with the home program supervised by the Residential Manager. Staffings are held with houseparents, Residential Manager, School Director, teachers, and consultants on a regular basis. Treatment plans are established, reviewed and revised by this group.

Program emphasis at McDonough House covers the following areas:

1) Skills for Independent Living - The teaching of self-care and daily living skills is a primary thrust of the program. Careful attention is given to those areas that would make the person a functioning and productive family member. These skills include: household tasks such as sweeping, making beds, laundry, preparing meals, setting and clearing the table, loading dishwasher and vacuuming. Also included are those self-help skills such as bathing, shampooing hair, dressing and personal hygiene tasks.

2) Socialization - Those skills that contribute to appropriate interactions with family and peers are stressed in the program. Communication skills, whether verbal, written, or sign are taught within the context of daily living. The development of leisure skills for individual as well as group activities are important; as well as developing structures which provide a productive and efficient family unit.

3) Coping Skills - A vital part of the treatment plan is the establishment of the confines under which each person best functions. Defining the limits of self-control aids the staff in establishing the amount of stress each person is able to handle in given situations.

A DESCRIPTION OF AN INNOVATIVE ALTERNATIVE SUMMER SCHOOL PROGRAM FOR EMOTIONALLY DISTURBED ADOLESCENTS IN A RESIDENTIAL TREATMENT CENTER

Robert J. Devlin
Louisiana State University

Special School District #1 (SSD #1) is an intermediate educational agency established in Louisiana in 1927. It was included in the statutory act which was intended to bring state law into line with Public Law 94-142. SSD #1 serves the educational needs of all students in public residential treatment programs. While there are some exceptions, the constituents of SSD #1 include students in juvenile correction institutions, facilities for the mentally retarded and for the emotionally disturbed. The goal of SSD #1 is to provide special education and related services to identified handicapped individuals, ages 3 through 21, residing in public residential facilities.

Greenwell Springs Hospital, a component of SSD #1, is a residential facility for emotionally disturbed adolescents. It is located near the city of Baton Rouge, the state capital and a large metropolitan area. The educational services are one component of the total service delivery system. SSD #1 enhances the role of that educational component.

The following statements reflect the principles of Special School District #1 and the faculty at Greenwell Springs Hospital.

I. We believe in:
   a. the principle of normalization;
   b. the basic right to a free and appropriate education;
   c. the personal dignity of the individual; and
   d. the opportunity for independent, functional living based on each individual's capabilities.

II. We believe that each individual is entitled to:
   a. an appropriate diagnostic/prescriptive assessment;
   b. an equal access to qualified educational personnel;
   c. a continuing programming for functional living within the least restrictive environment;
   d. a program that will assist each individual to achieve vocational, leisure, social and independent living skills in keeping with his/her individual's needs; and
   e. services enabling each individual to maximize his or her potential.

Putting the aforementioned principles into practice is accomplished through planned learning activities. These activities constitute the curriculum which falls into three interrelated comprehensive areas: (1) general education (also referred to as common learnings, unified studies, or core); (2) exploratory, special interest, and enrichment education (electives that are independent of any specialized curricular pattern); and (3) specialized education (pre-vocational and vocational studies).

During the regular school year emphasis is placed on general education. A full complement of both remedial and traditional high school courses are offered. Students are enrolled in a program granting Carnegie Units to be applied toward a high school diploma. Along with this traditional core, a full complement of remedial courses are offered: remedial math, reading and language arts. Pre-vocational and vocational studies are offered through Vocational Rehabilitation Program with functional living classes added through the school.

Since the treatment plan for the exceptional students at Greenwell Springs Hospital requires a 12-month educational program, the school developed an alternative program for the summer to help students reach their academic, social, emotional, and physical potential. The summer program concentrates on the exploratory, special interests, and enrichment areas while still providing functional living classes. Approximately 80 behavior disordered and emotionally disturbed adolescents ranging in age from eleven to seventeen participated in this program.

The faculty established through library research that self discipline is an essential goal of any curriculum. In order to facilitate student self discipline, a living curriculum based on functional skills and communication is needed.

This curriculum could be easily integrated into our yearly programming as a summer school alternative that emphasized group interactions and group communication to foster not only self discipline but functional and practical living skills. Summer courses are not credit so that pressure to academically perform is lessened.

The following is a list of the courses available at Greenwell Springs Hospital School during the summer. The students make selections from this list.

Law and Justice: How Does Our Legal System Really Work?

In the class you will become aware of personal responsibilities and legal rights while studying the operation of the justice system. Various aspects of law enforcement including problems faced by policemen of the sequence involved from arrest to final court judgment are explored. Enrichment activities include guest speakers, films, and field trips.

French

Laissez le bon temps roulet! (Let the good times roll!) In this class you will learn selected French vocabulary such as objects in the classroom, days of the week, colors, numbers, and names of family members. A field trip will be planned to explore our French heritage (Downtown Museums).

Journalism: The School Newspaper

In this class you will write and publish the Greenwell Springs School Newspaper. The paper will include interviews of teachers, students, and hospital staff, an advice column, jokes, poems, such as layouts, typing, interviewing and printing. A field trip to the Morning Advocate will be included.

Drug Use: Legal and Illegal

In this class you will learn unbiased factual information about drug use. How prescription and non-prescription drugs affect you physically and mentally. The Adolescent Substance Abuse Treatment Unit will be discussed. Enrichment activities include guest speakers and films.

Let's Go Camping

In this class you will explore the aspects of camping. This will include learning different types of plants, what to use when going camping, and assembling equipment. Films will be shown and the outdoors will be explored. A possible camping trip will be scheduled.

Gardening

In this class you will learn to grow houseplants and produce a garden. Plant identification, transplanting and rooting plants, proper ways to grow plants, and useful and non-useful insects will also be studied. Come and garden with us and take a house plant back to your room.

Physical Education

Have a relaxing summer - Come join our class and enjoy a summer full of tennis, volleyball, and recreational games (pool, ping pong, cards, etc.)

Driver's Education: Classroom Phase

In this class, you will learn how traffic laws and signs add to the legal and moral responsibility of the driver. Also, the techniques for coping with bad weather, emotions, and fatigue will be stressed. You must be 15 years of age.

Creative Writing

In this class, the development of creative writing skills will be explored. The exploration of your emotions and your five senses will help you write creatively. You will learn to write poetry, short stories and other forms of fiction in a workshop atmosphere.

Consumerism

In this class you will study buying skills such as buying a car, food shopping, buying clothes, catalogue and telephone shopping. Field trips will be scheduled to a grocery store, a department store and the Dollar General Store.

Living Skills: Getting By Day-To-Day

In this class basic living skills such as telephone skills, taxes, health (including seeing a doctor, counting calories, and dental hygiene) handling emergency situations, and becoming aware of what resources are available to you in your community. Use of the library will be stressed.

Career Awareness: What Do You Want To Be?

In this class you will explore various career opportunities. You will learn the basic skills for finding a job, pre-vocational skills, The jobs at Greenwell Springs Hospital will be studied and speakers from the different areas will be brought in to talk about their area of work.

You and Your Health: Everything You Wanted to Know About Yourself But Were Afraid To Ask

In this class, general health will be taught. This will include the body functions, smoking, reproductive system, filling out applications and health records, and first aid. Projections into the future, role playing and "truth and fable" games will be played to examine these subjects.

Drama - So You Want To Be A Star!

This class will produce a play "A Toby Show" which will be performed for the school and hospital staff. The students chosen for the character roles will learn the fundamentals of acting. The students chosen for the crew will reproduce the costumes, construct the lighting, properties and special effects.

Art

In this class, the props for "A Toby Show" will be designed, constructed, and painted. The basic stitches and techniques of embroidery will be taught. You will also have an opportunity to learn the fundamentals of commercial art.

Math and Computers

In the class you will review basic operations with numbers/ using a pocket calculator, run programs on a computer to increase arithmetic, spelling, and manual dexterity skills. Using BASIC language, you will be able to write a short program for the computer.

The last three classes represented a joint effort between drama, art, and math groups that resulted in production of a theatrical performance.

The Drama classes had the primary responsibility for producing the play. The Drama teacher directed the show and chose the cast and crews from the students in the three Drama classes. The actors or cast:

1. memorized their lines
2. attended rehearsals
3. developed their own rehearsal rules
4. learned to accept direction and criticism
5. co-operated to produce the final result.

The crews or technical people:

1. developed their own rules for rehearsals
2. designed and built lights and a dimmer board
3. collected or made hand properties
4. assisted with making costumes
5. were responsible for running the show during production
6. co-operated with crew members and actors to achieve the production goal.

The Art Classes took responsibility for the set. Members of these classes:

1. designed the set pieces
2. built the set pieces
3. painted the set pieces
4. decorated the set pieces.

The Math Classes were responsible for the business and financial management of the production. Members of these classes:

1. sold advertisements for the program bill
2. laid out the program pages
3. printed the program
4. comparison shopped for play production supplies and equipment
5. opened a bank account for the play, into which they made deposits or disbursed funds by either writing checks or allowing purchases
6. sold tickets to the play.

Day Treatment for Children and Adolescents: A Model Program for Provision of Services to the Severely Emotionally Disturbed

Dr. Laurel J. Kiser
Pamela Rubin
Cynthia Hill

Objectives of this presentation were to educate the community in regard to the philosophy, benefits and utilization of day treatment, to describe the services provided to patients in a working day treatment program (the University of Tennessee Day Treatment Program, Memphis), and to raise mental health service provision issues such as rising health care costs, community systems interaction, etc.

The presentation described the roles of the multidisciplinary staff of the U.T. Day Treatment Center, the target population and eligibility for program, and program offerings: individual, group and family therapy, education, activity therapy and nursing.

PREPARING TEACHERS FOR CHILDREN WITH LEARNING AND BEHAVIORAL DISORDERS IN A LIBERAL ARTS COLLEGE: A CRITERION PERFORMANCE PREPARATION MODEL

by

Byron R. Holmgren, Ed.D.
Professor of Education
Cumberland College

The Council for Basic Education has emphatically stated that "More than anything else, America's schools need competent teachers" (1981). In no area of American education is this statement more valid than in the field of special education. In view of the rapid growth of special education teacher education programs during the past quarter century, the foregoing statement seems to be particularly disturbing. If we are to justify the special nature of our support services, special education teacher education programs must produce teachers for the handicapped who are professionally competent. Professional competence should be manifest in intelligent behavior that promotes the use of appropriate technical and human skills.

TEACHER EDUCATION

Historically, teacher education has been the exclusive domain of state teacher colleges. Only more recently have private colleges ventured into this field. In the private sector, Catholic colleges and universities have provided the leadership for developing teacher education programs for handicapped learners. With the passage of the Education for All Handicapped Children Act of 1975 (Public Law 94-142), more private colleges have established handicapped teacher education programs. This trend will very likely continue through the mid 1980s.

While the demand for new teachers in our elementary and secondary schools have been declining during the past fifteen years, the demand for special education teachers at all levels has been increasing (Chandler, 1981). A direct result of this demand for more special education teachers has been the development and expansion of undergraduate and graduate teacher education programs in both public and private institutions.

Competency-Based Preparation Models

Competency-based teacher education (CBTE) or performanced-based teacher education (PBTE) is a relatively new movement that gained popularity, credibility, and momentum during the 1970s. The CBTE model, according to Hall and Jones (1976), evolved as a result of four separate and unrelated factors: (1) a teacher surplus, (2) a changing view of teacher education, (3) a public demand for accountability in the professional preparation of teachers, and (4) an increased commitment by federal and state agencies to research and development.

The concept underlying CBTE is competency. By definition, then, CBTE means mastering or reaching specific criteria for success in courses established by the faculty in teacher education programs. More specifically, it implies that the prospective teacher will acquire a predetermined number of competencies germane to each course he/she is enrolled in. Failure on the part of the prospective teacher to acquire these competencies at a predetermined criterion level will identify him/her as less competent than someone who meets or exceeds the minimal criterion level. Hence, the deficiencies will need to be overcome before moving on to the next module of instruction or major curriculum component.

To be sure, CBTE is not without its critics. One of the major justifiable criticisms is the totally inadequate research base to support the contentions of CBTE design (Hall & Houston, 1981; Maple, 1983). At our present level of research sophistication, the writer believes that this criticism could be overcome in this decade. Perhaps a greater obstacle to the development, implementation and maintenance of CBTE programs in any Department of Education is the inordinate amount of work connected with this teacher preparation model.

In spite of the opposition to CBTE, it appears to be an expanding model that has permeated colleges of education and state departments of education. Most emerging changes in teacher certification requirements embrace some aspect of the competency-based movement (NCES, 1981; Standard, 1976).

The remainder of this manuscript will address a specific aspect of CBTE, the performance criterion approach to preparing special education majors in a small, rural, church-related private college. The prospective special education teachers are being prepared to work with children who have mental, learning, and/or emotional disabilities.

THE CRITERION PERFORMANCE APPROACH

Teacher education in the field of special education has had only a very brief and undistinguished history. Two decades ago it was difficult to find prepared teachers for special education classrooms and even more difficult to hire adequately prepared teacher educators for this profession. The Kennedy-Johnson administration, together with the aid of some very capable and dynamic congressional leadership, provided the impetus for change through the passage of such significant pieces of federal legislation as PL 88-164, PL 89-105, PL 89-333, and PL 89-750 (Holmgren, 1968). With this legislation and commitment to change came an era of accountability.

It is difficult for most special education teachers to identify with a preparation model twenty-five years ago, because special education simply did not have a clearly identifiable teacher education model. It was closely patterned after the traditional teacher preparation model for regular classroom teachers. It was not until the late 1960s that special education began to assert itself as a viable professional preparation area within the educational establishment. The reasons for this professional metamorphosis were indicated above: they included the commitment by the federal government to support teacher education programs for exceptional children and youth, and the need to hold teacher educators accountable for their products. These demands necessitated more vigorous recruitment efforts at all levels of teacher education preparation, more rigorous entrance and exit requirements, and the maintenance of strong viable preparation components.

A Small College Experiment

Cumberland College is a small private church-related liberal arts college in southeastern Kentucky. It has an enrollment of approximately 1700 students with over forty percent of them majoring in some area of teacher education. Approximately one-fourth of the undergraduate majors in Special Education are pursuing certification in learning and behavioral disorders (L & BD). The Special Education program employs two part-time master's level teachers, one in learning disabilities and one in the TMH area. The college recently initiated an MA degree program in Education with an opportunity for the graduate student to concentrate in one of four areas: Early Childhood, Elementary, Reading, and Special Education. The Graduate Program in Special Education employs one full-time doctoral level person who also teaches part-time in the undergraduate program.

Entrance requirements. Students intending to enter the field of special education are encouraged to declare this major at some point during their sophomore year. Minimum requirements for admission to the special education teacher education program include: (1) passing tests designed to measure skills in basic literacy, oral and written communication, reading, writing, and computational skills, (2) satisfactory completion of a basic concepts course in education, (3) have a grade point average of 2.25 on a 4.0 scale, (4) exhibit moral, social and ethical behavior commensurate with the standards embraced by the school and community, and (5) make formal application to the Teacher Education Committee and schedule a formal interview with this group. Final admission to the Teacher Education program is determined by the Teacher Education Committee which also acts as the Admissions Committee. Subsequent to being formally admitted to the Teacher Education program, the student pursues his/her major course work under the direction of the major advisor. Figure 1 illustrates the formal teacher preparation process at the college.

Course sequence. In order for special education majors to maximize their learning and performance opportunities, they are advised to take courses in the sequence illustrated in Table I. The most compelling reason for advising the prospective teacher to follow the outlined sequence is so they can utilize prior knowledge and skills that are considered prerequisites to the subsequent courses. An example of this rationale is to have all students take SED 233, Survey of Special Education, as their first course because it provides a broad overview to all exceptionalities, a philosophy of special education support services, and the premise

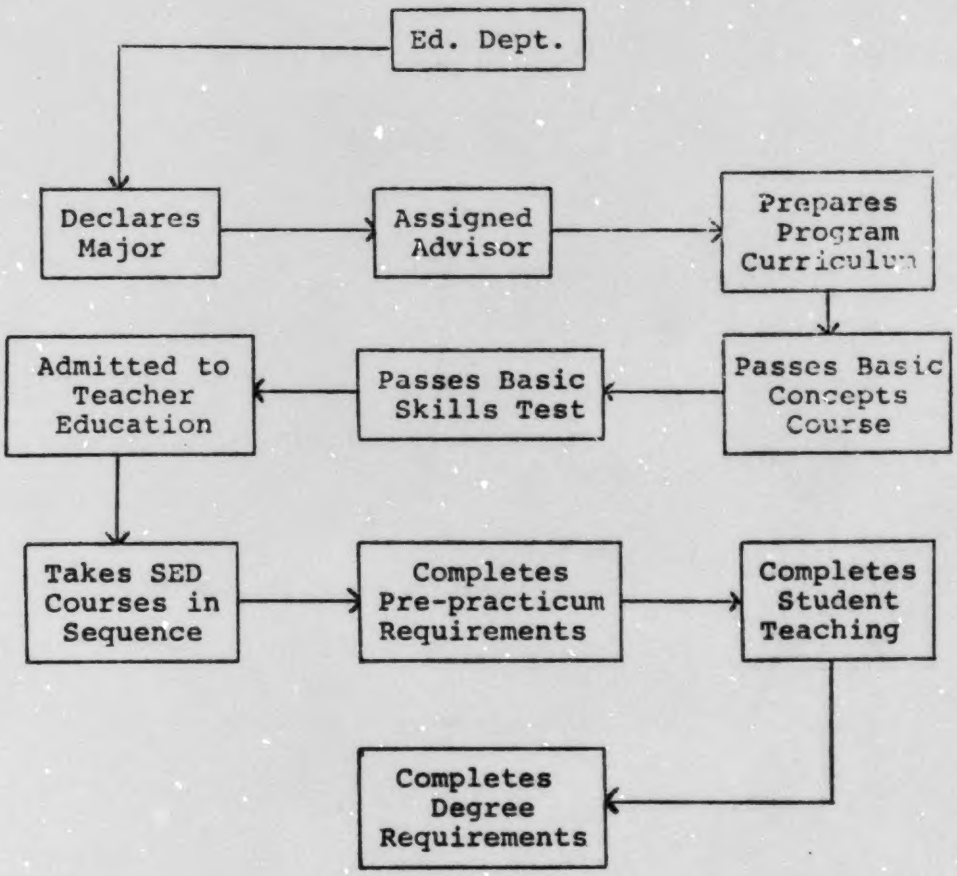
Ed. Dept.
Declares Major
Assigned Advisor
Prepares Program Curriculum
Passes Basic Concepts Course
Passes Basic Skills Test
Admitted to Teacher Education
Takes SED Courses in Sequence
Completes Pre-practicum Requirements
Completes Student Teaching
Completes Degree Requirements

Figure 1. Flow chart of Special Education Teacher Education Degree Process

for mainstreaming exceptional children. This course provides the requisite knowledge and experiences for entrance into SED 330, Field Experiences, and the other Special Education courses that follow.

Performance criteria. Each student enrolled in the writer's courses is administered a pretest of knowledge regarding the content of the course during the first class session. An example of pretest items is presented in Table II. The pretest also is used as a post-test and is admin-

TABLE I

COURSE SEQUENCE FOR L & BD MAJORS

SED 233.	Survey of Special Education
SED 330.	Field Experiences
SED 341.	Special Education Instructional Programs
SED 342.	Special Education Early Childhood Programs
SED 344.	Career Education for Exceptional Children
SED 432.	Educational Assessment of Exceptional Children
SED 433.	Prescriptive Programming
SED 445.	Special Education Methods and Materials
SED 499.	Supervised Student Teaching: Exceptional Children

istered on the last day of the term, preceding the final examination. Every student is expected to get seventy percent (70%) of the items correct on the post-test exercise. His/her performance on this activity is compared with performance or other assignments and activities during the semester. An overall performance criterion level of eighty percent (80%) proficiency is required in the course in order to advance to the next sequence. For example, students not attaining this proficiency level in SED 432, Educational Assessment of Exceptional Children, would either take this course over again or make up the deficiencies before being advised to enroll in SED 433, Prescriptive Programming for Learning and Behavioral Disorders. An example of course requirements and evaluation components is presented in

TABLE II

PRE/POST TEST FOR SED 432

___ Mental measurements yearbook

___ Assessment data in graphic form

___ Establishing the assessment relationship

___ Assessment of social acceptance

___ Measuring what it is designed to measure

___ Measures the individual's mastery of a specific skill

___ The use of standardized norm-referenced tests

___ Scores that indicate the mean, mode, and median

___ The pathways of learning

___ A device designed to assess adaptability

___ A comprehensive individual intelligence test for children

___ A learning aptitude test

___ An informal assessment device

___ A receptive vocabulary test

___ An individual achievement test

A. Validity

B. Criterion Reference Test

C. Formal Assessment

D. Buros

E. Profile

F. Measure of Central Tendency

G. Modalities

H. Vineland Social Maturity Scale

I. Sociogram

J. Rapport

K. SIT

L. Readiness Checklist

M. PPVT

N. Detroit

O. PIAT

P. WISC-R

Q. Metropolitan Achievement Tests

Table III. Table IV presents an example of performance activities and the minimal criterion for determining competence. The tables clearly indicate that ample opportunities are provided for the students to acquire knowledge and skills essential to successful teaching. The writer believes that

TABLE III

COURSE REQUIREMENTS AND EVALUATION FOR SED 432

Activities	Evaluation*
Examination of five assessment instruments	10%
Test Review	15%
Test Demonstration	10%
Problem Exam	15%
Completed Protocol Sheet and Profile Sheet	5%
Mid-Term Exam	20%
Final Exam	25%
	100%

*Each activity is evaluated as a percent of 100. Letter grades are assigned as follows:

A	100 - 91
B	90 - 81
C	80 - 71
D	70 - 61
F	60 - Below

prospective teachers who follow the suggested course sequence and acquire the requisite knowledge and competencies under at least the minimal performance criterion will be adequately ready to engage in a successful student teaching practicum experience. The preceding approach should help to reduce the chance factors in producing competent teachers for children and youth who exhibit mild learning and behavioral disorders.

Retention procedures. The minimum requirements for retention for students in the special education teacher education program include satisfactory completion of course work,

TABLE IV

PERFORMANCE OBJECTIVES FOR SED 432*

1. Ability to differentiate between norm and criterion-referenced testing procedures.
2. Knowledge regarding the psychometric properties of a standardized test.
3. Knowledge regarding measures of central tendency.
4. Ability to interpret normative data.
5. Ability to outline and follow systematic procedures in conducting an educational assessment.
6. Ability to identify and discuss factors that affect a child's school performance.
7. Ability to specify procedures for conducting a task analysis.
8. Ability to identify standardized tests commonly used in the assessment of cognitive abilities.
9. Knowledge of early childhood development.
10. Knowledge regarding which psychoeducational instruments to use in assessing a preschool handicapped child.
11. Ability to identify formal and informal procedures for assessing reading skill development.
12. Ability to qualify and quantify a specific learning and/or behavior problem.
13. Knowledge regarding criteria and regulations for placing handicapped children in special education programs.
14. Ability to assess and diagnose learning problems in the basic school subjects.
15. Ability to profile psychometric data accurately.

*Minimal performance criterion is 80% mastery of the above items as determined by instructor observation, demonstrations, paper and pencil tests, performance tasks and check sheets.

while maintaining a grade point average (GPA) of 2.50. The student must also have had a minimum of 100 clock hours of clinical and field experiences relative to handicapped learners, excluding student teaching. In addition, the prospective teacher must have demonstrated good moral, social, and ethical behavior while in attendance at the college.

SUMMARY AND CONCLUSIONS

During the foregoing discussion the writer has attempted to briefly review the rapid growth of special education teacher education preparation programs at all levels in both public and private colleges. The accelerated growth of these programs generated a need for developing more rigorous performance criteria in producing a competent teacher for handicapped learners. The writer recognizes that there are other viable approaches to teacher preparation for special educators. However, in a small college with one or two staff members, a large teacher education student enrollment and limited resources, great care must be taken to ensure quality instruction which will enable the prospective teacher to reach maximum competence in terms of his/her potential. For a more definitive discussion regarding variables affecting the quality of special education teacher education programs, the reader is referred to a recent article by Wheatley, Shuster and Schilit (1983).

During the past decade the writer has become convinced that the profession is producing and retaining more competent special education teachers. He does not agree, however, with the notion recently posited by Gallegos and Gibson (1982) that self-selection seems to be weeding out the poorer students in teacher education programs. Special education teacher education programs will continue to attract an inordinately high percentage of prospective teachers with marginal aptitude because of its blighted professional image. Yes, what America's schools need more than anything else is competent teachers, special education notwithstanding.

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APPENDICES

Appendix A

Conference Planning Advisory Committee

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Appendix B

This conference was made possible by a grant from the United States Department of Education, Division of Personnel Preparation, SEP/OSERS, Grant No. G008102036.

CONFERENCE PROGRAM

Wednesday, April 27

8:00 REGISTRATION GRAND SALON

9:30 FIRST GENERAL SESSION GRAND SALON

Presiding	William M. Jenkins, Chairman, Department of Special Education & Rehabilitation, Memphis State University
Welcome	Robert L. Saunders, Dean, College of Education, Memphis State University
	Thomas G. Carpenter, President, Memphis State University
	Wanda Moody, Assistant Commissioner, Division of Education for the Handicapped, State of Tennessee

Keynote Speech: Meeting Their Needs Judith K. Grosenick
Introduction of speaker-Wanda Moody

10:30 COFFEE BREAK GRAND SALON

11:00 Working with Parents of Adolescents Identified as Emotionally or Behaviorally Disordered Richard L. McDowell
Introduction of speaker-Harold W. Perry

12:00 LUNCH

1:30 SMALL-GROUP PRESENTATIONS

GRAND SALON I

Pulling It All Together: Programs for Autistic and Emotionally Disturbed Students in the Memphis City Schools Elizabeth Montague, Carol Randalls, Dennis Medford, Mickey Spence, Teri Petrovsky-Lewis, Carolyn Moore, Jenny Baer, Carol McKinney

An overview of the multi-faceted services developed to meet the educational needs of these students. Program descriptions, language therapy models, behavioral interventions and strategies will be presented.

GRAND SALON II

Autism: Accepting and Understanding It Within the Family Context Sam B. Morgan, Scott W. Henggeler, William Haefele

Discussion of points to be considered in initial counseling of parents and other family members; analysis of impact of the autistic child on the family system and on family members' interactions with outside systems; suggestions for optimizing the psychosocial functioning of family members.

PLANTATION ROOM

Reinforcement and Punishment: Relative Cost Effectiveness in Behavior Reduction Programs Deborah T. Orr, Walt Antonow, F. J. Eicke

Presentation of research conducted on common behavioral techniques, with in-depth discussion of results and implications; training in implementing the techniques and applying the techniques researched to individual settings.

SOUTHERN SUITE

Improving the Social Acceptability of Emotionally Disturbed Children Barbara Marotz

Alternate ways of measuring and improving the social acceptability of emotionally disturbed elementary school students will be addressed. Change methods include social skills training, "hero" procedures, the "barb" technique, use of peer helpers, and more. Also included are suggestions on ways to change attitudes of peers and teachers.

SHOWBOAT ROOM

A Criterion-Performance Model for Preparing Teachers for Children with Learning and Behavior Disorders Byron R. Holmgren

A description of one small private college's approach to preparing undergraduate special education majors for certification as teachers for children with learning and behavior disorders. The overview will include aspects of selection process, development of performance skills, and retention procedures.

LEVEE ROOM

Using Developmental Drama to Enhance the Emotional and Social Growth of Seriously Disturbed and Autistic Adolescents
Cynthia L. Warger

Developmental drama is presented as a viable program option for these students. Specific emphasis will be placed on how to structure activities for educational, social, recreational, and therapeutic purposes. Techniques for modifying activities to meet individual needs will be included, as will strategies for linking drama activities to IEP objectives. Special training in drama is not needed.

2:45 BREAK

3:15 SECOND GENERAL SESSION GRAND SALON

Curriculum Issues in Educating Students with Autism and Other Severe Handicaps Anne M. Donnellan
Introduction of speaker-Richard Johnson

5:30 SOCIAL HOUR (Cash Bar) Honoring the Presenters SOUTHERN SUITE

Thursday, April 28

8:30 SMALL GROUP PRESENTATIONS

GRAND SALON I
Developing Programs for Meeting the Criterion of the Least Dangerous Assumption Anne M. Donnellan

GRAND SALON II
The Allan Cott School: Educational and Residential Services for the Autistic Betty Milner

The presentation will describe the services of this school, which provides comprehensive educational and residential services to autistic students, ages 6 through 21. It will include a discussion of the program, treatment modalities, and the educational/medical approach.

SHOWBOAT ROOM
Strategies for Dealing with "Burnout" in Parents of Older Emotionally Disturbed Children Gary N. Morrison, Merrie B. Morrison

The problem of "burnout" in parents of older severely emotionally disturbed children will be explored, and some techniques designed to assist parents in dealing with this problem will be presented.

SOUTHERN SUITE I
Working with Siblings of Handicapped Children Gwen Benson

Participants will be provided with various strategies that can be used when working with siblings of handicapped students. Description and results of a two-day workshop will be presented along with appropriate settings, suggested materials, and pre- and post-tests.

SOUTHERN SUITE II
Clinical and Educational Perspectives on Language Intervention with the Emotionally Disturbed and Autistic Alan G. Kamhi, Lauren K. Nelson, Lacy H. Wray

Some criteria and guidelines for effective language intervention will be presented in the context of a general theoretic framework, followed by an evaluation of current approaches to language training with the emotionally disturbed and autistic. The role of the special educator and other non-language specialists as facilitators of language development will be discussed, and some specific ways to optimize the language learning environment will be presented.

LEVEE ROOM
Increasing Attending to Task Behavior and Academic Productivity of Severely Behavior Disordered and Deaf/Severely Behavior Disordered Adolescents Lonny W. Morrow

A technique and variations which have been successful in increasing attending behaviors and academic productivity in this population will be described. Data from a multiple baseline across subjects design will be presented.

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9:30 COFFEE BREAK — GRAND SALON

10:00 THIRD GENERAL SESSION — GRAND SALON

The Use of Mild Aversives with Self-Injurious Behavior
Paul A. Alberto
Introduction of speaker-Rose Porter

11:30 LUNCH

12:30 SMALL GROUP PRESENTATIONS

GRAND SALON I
Exclusionary Practices with Disturbed Students Judith K. Grosenick

GRAND SALON II
Providing Educational Services to Adolescents and Adults with Autism in a Fully Integrated High School Setting Bernard H. Travnikar

The Oakland Schools Program disproves the belief that such services cannot be appropriately provided in such a setting. Considerations which should be taken into account when planning to provide such services will be addressed, as well as the recognition of resources that exist in the naturalized educational environment.

SHOWBOAT ROOM
The Parents and Siblings of the Severely Emotionally Disturbed: Positive Interaction Richard L. McDowell

SOUTHERN SUITE I
A Description of an Innovative Summer School Program for Emotionally Disturbed Adolescents in a Public Residential Facility Robert J. Devlin

An innovative alternative summer school program, designed for eighty adolescents in this residential facility, is described. These students ranged in age from eleven to eighteen. The alternative sets of elective courses emphasized group interaction and group communication.

SOUTHERN SUITE II
Children in Crisis: The Academic Effect Jimmie E. Cook

This presentation investigates the effects of death, divorce, abuse, hospitalization, etc., on the academic performance of children in grades K-8. Research reveals that such crises can impede a child's performance for years beyond the onset of the crisis.

LEVEE ROOM
Restraint as a Positive Reinforcer: A One-Year Followup
Mary Anna Springfield

A description documenting the methodology used to lessen aggressi noncompliant and withdrawal behaviors will be presented. A brief slide presentation will show sequential places involved in modifying these inappropriate behaviors by use of restraint as a positive reinforcer.

1:45 BREAK

2:15 SMALL GROUP PRESENTATIONS

GRAND SALON I
Selecting Appropriate Non-Verbal Systems for Use with the Autistic or Severely Emotionally Disturbed Paul A. Alberto

GRAND SALON II
Decreasing Aggression and Self-Harm: Prevention and Intervention Techniques Useful with the Severely Emotionally Disturbed Client
Walt Antonow, Deborah T. Orr

Note: This workshop will continue through the 3:45-4:45 mini-session period.

Presentation and demonstration of appropriate techniques. Content of the workshop will deal with structuring the environment to prevent crisis situations as well as presenting techniques which are practical in dealing with crisis situations such as client physical aggression and self-injurious behavior. Audiovisual aids will be used during the first part of the presentation. Active audience participation may be expected, if the size of the audience group and their prior familiarity with intervention techniques make this appropriate.

SHOWBOAT ROOM
Meeting the Needs of Autistic Individuals in a Comprehensive Community Based Service Provider for the Developmentally Disabled
Daniel B. Rosen, Rose A. Adams, Rusty Sheridan, Jay Whitsitt, Nancy Rogers

The session describes the transition of a large service provider from an agency providing only educational services to mentally retarded school-age children to a comprehensive provider (of educational, residential, vocational services) for all ages and types of developmental disabilities, including autism, even in the face of a constricting economy. Emphasis will be placed on unique programs, especially an educational service for autistic/autistic-like persons. Issues addressed will include methodology, program design, and the use and interfacing of numerous funding sources. Administrative as well as operational concerns will be discussed.

SOUTHERN SUITE I
The Behavior Evaluation Scale: An Instrument for Identifying Behaviorally Disordered Children and Youth (K-12), Designed to Operationalize the Definition of PL 94-142 Stephen B. McCarney, James E. Leigh

Introducing a new nationally standardized instrument designed to assist school personnel in identifying and diagnosing behaviorally disordered students as well as contribute to a comprehensive assessment of any student who may require special education services. Audience members will receive a sample complimentary copy of the BES protocol and will participate in an activity to illustrate use of the instrument.

SOUTHERN SUITE II
Vision Screening for the Severely Emotionally Disturbed and Autistic Andrea Sizemore

This session will present specific vision screening techniques which can be used with severely emotionally disturbed and autistic children. Included will be an overview of vision problems, discussion of vision screening instrument options, methods for screening this population, and implementing the referral process.

LEVEE ROOM
Learned Helplessness: A Family Perspective John G. Greer, Chris E. Wethered

Learned helplessness is a phenomenon wherein people are repeatedly exposed to situations beyond their control. Such exposure results in passivity, decreased interest and a reduction in the initiation of responses. This presentation provides insight into these problems as they are experienced by handicapped children and their parents. Treatment strategies will be presented.

3:30 BREAK

3:45 SMALL GROUP PRESENTATIONS

GRAND SALON I
What We Wish They Knew David F. Freschi

Description of a model community program for autistic adults and others with similar severe behavioral problems will be given. Characteristics of a successful program as well as learning needs for clients prior to seeking an adult placement will be identified and discussed.

GRAND SALON II
Continuation of Workshop on Decreasing Aggression and Self-Harm
Antonow & Orr

SHOWBOAT ROOM
Motivating the Emotionally Disturbed/Learning Disabled Child: From a Model Program Approach to Practical Teacher Application
Dana P. Fredrick, and Special Education Staff

An overview of the Neuropsychological Treatment Program, a specialized program within the Child and Adolescent Psychiatric Service at Mid-South Hospital, will be presented. Using a multi-media approach, practical teacher-application techniques will be explored. Practical ideas for teacher application of suggestions, when multidisciplinary resources are not available, will be given.

SOUTHERN SUITE I
Prototype Assessment for Vocational Aptitude S. K. Setbacken
Albert J. Hardaway, Lena M. Sparks

A description of and rationale for the prototype assessment used as a predictor of vocational aptitude for the severely emotionally disturbed and autistic-like severe and profound retarded population of Arlington Developmental Center.

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SOUTHERN SUITE II

Day Treatment for Children and Adolescents: A Model Program for Provision of Services to the Severely Emotionally Disturbed

Laurel J. Kiser, Pamela Rubin, Cynthia Hill

The philosophy, need, multi-disciplinary staffing, patient population and program offering of this day treatment program are presented.

LEVEE ROOM

The Role of Mental Health in the Ministry of the Church

Theron Michael Covin

Mental health will be defined from a practical standpoint. The importance of mental health in the ministry of the church will be stressed. Practical delivery of mental health services by the church will be emphasized. Case histories will be used. Practical application to the participants' settings will be discussed.

Appendix C

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Appendix D

Evaluation of Conference

Ruth Bragman, Ph.D.

The conference, "Meeting Their Needs: Provision of Services to the Severely Emotionally Disturbed and Autistic," was held at the Ramada Convention Center Inn, Memphis, TN, on April 27-28, 1983. Attendance for the two-day conference was between 450 and 500. Fifteen states were represented: Alabama, Arkansas, Georgia, Illinois, Kentucky, Louisiana, Michigan, Mississippi, Missouri, New Mexico, New York, Ohio, Tennessee, Texas, and Wisconsin. Individuals attending represented different areas of involvement in service delivery, from parents to state program directors. (Table 1 lists professional backgrounds of individuals who completed evaluation forms.) Support from school systems was outstanding; for example, one large system gave professional leave days to all teachers and aides in classes for the emotionally disturbed and autistic in order that they might attend the conference. Sitter service was also provided parents of children in those classes who attended the conference.

The conference evaluation form is shown in Appendix E. A total of 120 evaluation forms returned gave a return rate of only 27%. Most of the returned forms were from persons who attended both days; earlier provision of easily available locations to return the forms might have improved the return rate. An announcement at the first general session giving simple suggestions for presentation evaluations at time of attendance would have made the evaluation procedure less a chore; this would have also improved the return rate.

The overall evaluation of the conference was high. These ratings are presented in Table 2. The many congratulatory comments and letters received since the conference confirm these positive evaluations.

For each session, including the general sessions, evaluations were completed as to content, presentation, and presentor. The results of the evaluations for the four general sessions are shown in Tables 3 through 6. Evaluations for the twenty-six small group presentations are not included in this Appendix, but are being made available to the presenters.

Over 50% of the sessions were rated as good (3.0) or better, with the ratings ranging from 2.33 to 3.90. These ratings may, however, be misleading. The number of returned forms for specific presentations varied from 2 to 103. The percent of forms returned in relation to the number of individuals who attended the session is unknown. By inspecting the written comments and by observation of many of the sessions, many more individuals are known to have attended the sessions than completed the forms. Many sessions were uncomfortably crowded. Another problem causing the reported low return rate for some sessions was that the session(s) being evaluated were not identified; the evaluation information could therefore not be used.

Generally the comments relating to the conference were positive, as were the evaluations. The only major problem noted was that many of the rooms were too small for the number of people wishing to see specific presentations. The large attendance at the conference had been underestimated by conference planners; this was the first time such a conference had been held by the Department, so that attendance could not be predicted.

Recommendations to ensure a higher return rate of evaluation forms at future conferences include:

- Collection of evaluation forms following each session
- Recording of the number of individuals at each session
- Use of a separate form for the all-over evaluation
- Designation at the start of the conference of central locations for return of evaluation forms

Table 1

Summary of Professional Backgrounds

Title	Day One	Day Two	Both Days	Unknown	Total
Teach.Trainer		1	4	2	7
Psychologist	1		2	1	4
Parent	1		4	1	6
Teacher		3	38	2	43
Prog.Dir.		1	7	4	12
Student			7		7
Other					
Dev.Tech.			5		5
Teach.Aide		1	3		4
Counselor		1		1	2
Soc. Work.	1		5		6
Speech.Path			2		2
Asso.Teacher			1		1
Psychomet.		1			1
Nurse			1		1
School. Admin.			1		1
M.R. Admin.			1		1
Consult.State			1		1
Tn.Dept.Ed.				1	1
Ala.Dept.Ed.			1		1
Consultant			2		2
Adminst.			1		1
Supervisor				1	1
Prog. Coord.			1		1
Occ. Therap.			1		1
Dir.Staff Dev.				1	1
Program Tech.			1		1
Dir.Vol.Service			1		1
Employee Dev.			1		1
Librarian			1		1
Unknown			1	2	3
Total	3	8	93	16	120

Table 2

Summary of Over-All Evaluation

	EXCELLENT		GOOD		FAIR		POOR		TOTAL	
	PERCENT	N	PERCENT	N	PERCENT	N	PERCENT	N	NUMBER	MEAN
FACILITIES	27	27	39	39	26	26	8	8	100	2.85
TIME ALLOCATIONS	29	28	52	50	16	15	4	4	97	3.05
RELEVANCE/VARIETY	54	49	44	40	2	2	0	0	91	3.52

Table 3

SUMMARY EVALUATION FOR:MEETING-THEIR-NEEDS

OVERALL-MEAN 3.22	EXCELLENT		GOOD		FAIR		POOR		TOTAL		
	PERCENT-N		PERCENT-N		PERCENT-N		PERCENT-N		NUMBER	MEAN	
CONTENT											
NEW	12	2	65	11	18	3	6	1	17	2.82	
RELEVANT	39	7	50	9	11	2	0	0	18	3.28	CONTENT
PRACTICAL	44	8	50	9	0	0	6	1	18	3.33	MEAN- 3.14
PRESENTATION											
CLEAR-OBJECTIVE	50	9	39	7	6	1	6	1	18	3.33	
ORGANIZED	50	9	39	7	11	2	0	0	18	3.39	PRESENTATION
INVOLVING	25	4	35	6	35	6	6	1	17	2.76	MEAN- 3.16
PRESENTOR											
INFORMED	71	12	24	4	0	0	6	1	17	3.59	
ARTICULATE	71	12	18	3	6	1	6	1	17	3.62	PRESENTOR
STIMULATING	38	6	38	6	24	4	6	1	17	3.01	MEAN- 3.37

Table 4

SUMMARY EVALUATION FOR:WORKING-WITH-PARENTS-OF-ADOLESCENTS-IDENTIFIED-AS-EMOTIONALLY-OR-BEHAVIORALLY-DISORDERED

OVERALL-MEAN 3.42	EXCELLENT		GOOD		FAIR		POOR		TOTAL		
	PERCENT-N		PERCENT-N		PERCENT-N		PERCENT-N		NUMBER	MEAN	
CONTENT											
NEW	32	29	48	43	14	13	6	5	90	3.07	
RELEVANT	50	48	38	37	9	9	3	3	97	3.34	CONTENT
PRACTICAL	63	59	23	21	10	9	4	4	93	3.45	MEAN- 3.29
PRESENTATION											
CLEAR-OBJECTIVE	53	48	28	26	15	14	4	4	92	3.28	
ORGANIZED	54	50	36	33	8	7	3	3	93	3.41	PRESENTATION
INVOLVING	62	56	26	23	10	9	2	2	90	3.48	MEAN- 3.39
PRESENTOR											
INFORMED	66	63	25	24	6	6	2	2	95	3.56	
ARTICULATE	67	62	29	27	3	3	0	0	92	3.64	PRESENTOR
STIMULATING	67	63	22	21	7	7	3	3	94	3.53	MEAN- 3.58

Table 5

SUMMARY EVALUATION FOR:THE-USE-OF-MILD-AVERSIVES-WITH-SELF-INJURIOUS-BEHAVIOR

OVERALL-MEAN 3.73	EXCELLENT		GOOD		FAIR		POOR		TOTAL		
	PERCENT-N		PERCENT-N		PERCENT-N		PERCENT-N		NUMBER	MEAN	
CONTENT											
NEW	68	67	30	30	1	1	0	0	98	3.67	
RELEVANT	78	77	19	19	1	1	2	1	98	3.73	CONTENT
PRACTICAL	76	75	21	21	2	2	2	2	100	3.69	MEAN- 3.70
PRESENTATION											
CLEAR-OBJECTIVE	78	80	20	21	2	2	0	0	103	3.76	
ORGANIZED	78	77	20	20	2	2	0	0	99	3.76	PRESENTATION
INVOLVING	66	61	30	28	4	4	0	0	93	3.61	MEAN- 3.71
PRESENTOR											
INFORMED	86	85	13	13	1	1	0	0	99	3.85	
ARTICULATE	82	81	17	17	1	1	0	0	99	3.81	PRESENTOR
STIMULATING	80	78	18	18	1	1	1	1	98	3.73	MEAN- 3.80

Table 6

SUMMARY EVALUATION FOR:CURRICULUM-ISSUES-IN-EDUCATING-STUDENTS-WITH-AUTISM-AND-OTHER-SEVERE-HANDICAPS

OVERALL-MEAN 3.65	EXCELLENT		GOOD		FAIR		POOR		TOTAL		
	PERCENT-N		PERCENT-N		PERCENT-N		PERCENT-N		NUMBER	MEAN	
CONTENT											
NEW	61	46	32	24	7	5	0	0	75	3.55	
RELEVANT	69	51	28	21	4	3	0	0	75	3.64	CONTENT
PRACTICAL	69	51	27	21	3	2	0	0	74	3.67	MEAN- 3.62
PRESENTATION											
CLEAR-OBJECTIVE	69	51	27	20	4	3	0	0	74	3.65	
ORGANIZED	68	50	29	21	3	2	0	0	73	3.66	PRESENTATION
INVOLVING	68	50	25	18	4	3	1	1	72	3.62	MEAN- 3.64
PRESENTOR											
INFORMED	73	54	26	19	1	1	0	0	74	3.72	
ARTICULATE	74	53	24	17	3	2	0	0	72	3.71	PRESENTOR
STIMULATING	68	49	26	19	6	4	0	0	72	3.63	MEAN- 3.69

Appendix E

CONFERENCE EVALUATION FORM

Thank you for taking the time to complete this form during your attendance here. Please complete portions relevant to sessions attended, and leave at registration table, front desk, or with any session moderator or Memphis State University faculty member. Any additional comments you wish to make will be welcomed.

***

I am a: _____Teacher trainer _____Teacher
_____Psychologist _____Program Director
_____Parent _____Student
_____Other (please specify)_______________________________ _____

I attended: First day only ______Second day only______Both days________

RATING OF CONFERENCE:	Excellent	Good	Fair	Poor
Facilities	____	____	____	____
Time Allocations	____	____	____	____
Relevance/Variety of Presentations	____	____	____	____
RATING OF GENERAL SESSIONS:				
1. Dr. Judith Grosenick: Meeting Their Needs				
Content:				
New	____	____	____	____
Relevant	____	____	____	____
Practical	____	____	____	____
Presentation:				
Clear Objectives	____	____	____	____
Organized	____	____	____	____
Involving	____	____	____	____
Presentor				
Informed	____	____	____	____
Articulate	____	____	____	____
Stimulating	____	____	____	____
2. Dr. Richard McDowell: Working with Parents				
Content:				
New	____	____	____	____
Relevant	____	____	____	____
Stimulating	____	____	____	____
Presentation:				
Clear Objectives	____	____	____	____
Organized	____	____	____	____
Involving	____	____	____	____
Presentor:				
Informed	____	____	____	____
Articulate	____	____	____	____
Stimulating	____	____	____	____
3. Dr. Anne Donnellan: Curriculum Issues				
Content:				
New	____	____	____	____
Relevant	____	____	____	____
Stimulating	____	____	____	____
Presentation:				
Clear Objectives	____	____	____	____
Organized	____	____	____	____
Involving	____	____	____	____
Presentor:				
Informed	____	____	____	____
Articulate	____	____	____	____
Stimulating	____	____	____	____
4. Dr. Paul Alberto: The Use of Mild Aversives				
Content:				
New	____	____	____	____
Relevant	____	____	____	____
Practical	____	____	____	____
Presentation:				
Clear Objectives	____	____	____	____
Organized	____	____	____	____
Involving	____	____	____	____
Presentor:				
Informed	____	____	____	____
Articulate	____	____	____	____
Stimulating	____	____	____	____

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EVALUATION OF SMALL-GROUP SESSIONS

1. Time: Day: Room:

Content:	Excellent	Good	Fair	Poor
New	____	____	____	____
Relevant	____	____	____	____
Practical	____	____	____	____
Presentation:				
Clear Objectives	____	____	____	____
Organized	____	____	____	____
Involving	____	____	____	____
Presentor:				
Informed	____	____	____	____
Articulate	____	____	____	____
Stimulating	____	____	____	____

2. Time: Day: Room:

Content:	Excellent	Good	Fair	Poor
New	____	____	____	____
Relevant	____	____	____	____
Practical	____	____	____	____
Presentation:				
Clear Objectives	____	____	____	____
Organized	____	____	____	____
Involving	____	____	____	____
Presentor:				
Informed	____	____	____	____
Articulate	____	____	____	____
Stimulating	____	____	____	____

3. Time: Day: Room:

Content:	Excellent	Good	Fair	Poor
New	____	____	____	____
Relevant	____	____	____	____
Practical	____	____	____	____
Presentation:				
Clear Objectives	____	____	____	____
Organized	____	____	____	____
Involving	____	____	____	____
Presentor:				
Informed	____	____	____	____
Articulate	____	____	____	____
Stimulating	____	____	____	____

4. Time: Day: Room:

Content:	Excellent	Good	Fair	Poor
New	____	____	____	____
Relevant	____	____	____	____
Practical	____	____	____	____
Presentation:				
Clear Objectives	____	____	____	____
Organized	____	____	____	____
Involving	____	____	____	____
Presentor:				
Informed	____	____	____	____
Articulate	____	____	____	____
Stimulating	____	____	____	____

5. Time: Day: Room:

Content:	Excellent	Good	Fair	Poor
New	____	____	____	____
Relevant	____	____	____	____
Practical	____	____	____	____
Presentation:				
Clear Objectives	____	____	____	____
Organized	____	____	____	____
Involving	____	____	____	____
Presentor:				
Informed	____	____	____	____
Articulate	____	____	____	____
Stimulating	____	____	____	____

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Appendix F

Gwendolyn T. Benson
Louisiana State University

Working with Sibling of Handicapped Children

Current prevalence figures suggest that about 12% of all school age children and youth exhibit some form of handicapping condition (Haring, 1982). In meeting the needs of this population and those immediately effected, legislation has been enacted which provides educational programming in addition to other related and supportive services.

These mandated services have had a tremendous impact on the lives of handicapped individuals and their families. Many new programs with emphasis on the handicapped individuals and their parents have been developed and implemented. Attention has mainly been directed toward the father-mother and the parent-handicapped child relationship. Consequently, one significant group, the siblings of the handicapped child have been overlooked.

Traditionally, investigations have focused on parental coping with the presence of a handicapped child in the family (Simeonsson & Simeonsson, 1981). In other research, the effect of the handicapped child has been considered in terms of the family system as a whole (Farber, 1960). In addition, investigations have focused on the reaction of individual family members to the presence of the handicapped child. Much of this research has been directed at documenting the response of the parents, usually the mother, who lives with a handicapped child (Farber, 1960; O'Connor & Stachowiak, 1971; and Burden, 1980). Much less research has been concerned with the reaction of the other individual family members, that is, the sibling of handicapped children. While some of the consequences of having a handicapped sibling have been described (Farber & Ryckman, 1965; Dunlap & Hollingsworth, 1977), sibling of handicapped children rarely receive support of any kind. They tend to go unnoticed until a persistent problem demands attention. This may be in the form of problems in school, both behavioral and learning problems; emotional problems stemming from guilt, unintentional neglect by parents, overwhelming responsibility for one's sibling; family problem such as divorce, financial strain, communicating with peers and simply understanding a specific handicapping condition.

The preceeding problems, along with the lack of research conducted concerning sibling of handicapped children, suggest a need for development and implementation of preventative and ongoing strategies.

In order to determine if intervention is necessary, parents and professionals must be able to recognize when a problem exist. Munson (1978) suggests a number of symptoms may be experienced by sibling. These include enuresis, headaches, poor school performance, school phobia, depression, and severe anxiety. Other symptoms described by Wiener (1970) range from no apparent response at all to depression, nightmares,aggression and somatic complaints. In summarizing these symptoms, it is important for parents and professionals to observe information concerning school work, appetite, sleep patterns and discipline.

Researchers also suggest that siblings express many feelings that parents should acknowledge (Bank & Kahn, 1982). First, responsibility for a sibling's handicap might generate guilt over one's advantages, guilt over angry feelings or guilt for hostile feelings. Second, specific fears might be expressed such as fear of having children themselves; the possibility of becomming handicapped like brother or sister; fear that parents do not care about them; and fear that the handicapped child will die. It is important to note that these feelings may not always be expressed in ways that are understandable to parents. Therefore, close observations by professionals and other family members are necessary.

After it has been determined that a problem exists, a number of factors should be considered: developmental stage, rate or onset and chronicity of handicapped sibling's problem, and degree of embarrassment or stigma associated with the perception of a siblings handicapping condition, particularly if perceived as socially disgusting or socially unacceptable.

Intervention strategies may take a variety of forms, such as group sessions where siblings can air out differences among each other, individual therapy sessions or workshops.

The following is an example of a two-day sibling workshop that was designed for sibling of handicapped students attending a private preschool program. Handicapped students in the program ranged from mild/moderate to severe/profound. A total of 52 sibling participated in the two-day workshop. Provided below is the rationale, development, implementation and results of the workshop.

Sibling Workshop

Rationale

I. Parent Concern regarding attitude and actions of nonhandicapped sibling

II. Bringing Sibling of Handicapped students together

III. Learning to deal with feelings

IV. Maximizing benefits of time shared

V. Facilitating positive interactions

Development

I. Consider ages of nonhandicapped sibling -

Ages were 6 to 18 years, under 6yrs parents were required to attend

II. Number of sibling participating

52 sibling participated for the two-day period.

III. Time required

Two days were decided in order to provide small group informational sessions on the first day and a larger group activity on the second day.

IV. Site

The private preschool was considered the most appropriate site for the first day of activities because sibling would be provided with an opportunity to observe their brothers or sisters in school and they could also tour the school.

V. Content

Two-day of informational and fun-filled activities.

Implementation

I. Day I sessions
    A. Attitude Test
    B. Session on Feelings and Emotions
    C. Informational Session
    D. Classroom Observation
    E. Socialization Activities
    F. Film Festival
    G. Discussion
II. Day 2 Lake Outing
    A. Tour of Missouri Town
    B. Planned Games and Activities
    C. Picnic Lunch
    D. Swimming

Results

I. Double Participation
II. Better Understanding of school For handicapped siblings
III. Discovery of other sibling who shared common feelings
IV. Learning to work and play more appropriately with handicapped sibling
V. Learning to be more tolerant of time parents devote to handicapped sibling

In summary, the workshop proved to be quite successful. Parents, teachers and of course sibling agreed that the project was beneficial to all participants. In following up this activity, the school director plans to make the workshop an annual part of the school's agenda.

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